

103^D CONGRESS
1ST SESSION

H. R. 1398

To amend the Internal Revenue Code of 1986 and the Social Security Act to provide for health insurance coverage for workers and the public in a manner that contains the costs of health care in the United States.

IN THE HOUSE OF REPRESENTATIVES

MARCH 18, 1993

Mr. CARDIN introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, and Education and Labor

A BILL

To amend the Internal Revenue Code of 1986 and the Social Security Act to provide for health insurance coverage for workers and the public in a manner that contains the costs of health care in the United States.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Flexible Medical Access and Cost Containment Act of
6 1993”.

7 (b) TABLE OF CONTENTS.—The table of contents of
8 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—REQUIRING EMPLOYERS TO PROVIDE HEALTH
INSURANCE COVERAGE FOR EMPLOYEES AND DEPENDENTS

Sec. 101. Requirement.

Sec. 102. Meeting requirement through enrollment of employees and families
under qualified employer health plans.

“TITLE XXI—REQUIREMENT FOR ENROLLMENT OF EMPLOYEES
UNDER A QUALIFIED EMPLOYER HEALTH PLAN

“Sec. 2100. Relation to Internal Revenue Code requirement.

“PART A—EMPLOYER REQUIREMENT TO ENROLL EMPLOYEES AND FAMILIES
IN A QUALIFIED EMPLOYER HEALTH PLAN

“Sec. 2101. Application to full-time employees.

“Sec. 2102. Application to part-time employees.

“Sec. 2103. Application to seasonal and temporary employees.

“Sec. 2104. Treatment of all family members as a unit; uniform treatment
of full-time employees and of part-time employees.

“Sec. 2105. Application of requirement to employers of different sizes.

“Sec. 2106. Timing of enrollment; period of coverage.

“PART B—REQUIREMENTS FOR QUALIFIED EMPLOYER HEALTH PLANS

“Sec. 2121. Qualified employer health plan defined.

“Sec. 2122. Requirements relating to employee premiums and cost-shar-
ing.

“PART C—STANDARDS FOR QUALIFIED HEALTH PLANS

“Sec. 2151. Certification of qualified health plans.

“Sec. 2152. Treatment of family as a unit; coverage period; health plan
cards.

“Sec. 2153. Requirements respecting basic benefits.

“Sec. 2154. Requirements respecting limits on pre-existing condition exclu-
sions and coverage standards for basic health services.

“Sec. 2155. Requirements respecting limits on cost-sharing.

“Sec. 2156. Use of payment rates.

“Sec. 2157. Coordination and portability of health coverage under quali-
fied health plans.

“Sec. 2158. Consumer protections.

“Sec. 2159. Preemption of certain state and federal requirements.

“Sec. 2160. Use of uniform claims forms; uniform information reporting.

“PART D—DEFINITIONS AND MISCELLANEOUS

“Sec. 2181. Definitions.

“Sec. 2182. Nonapplication to residents of Puerto Rico and territories.

Sec. 103. Repeal of COBRA continuation requirements.

TITLE II—PROVISION OF HEALTH INSURANCE THROUGH A
PUBLIC HEALTH PLAN

Sec. 201. Public health plan.

“TITLE XXII—PUBLIC HEALTH PLAN

“PART A—ELIGIBILITY AND ENROLLMENT

- “Sec. 2201. Eligibility to enroll for health insurance benefits and to apply for low-income assistance.
- “Sec. 2202. Application for enrollment.
- “Sec. 2203. Coverage period; termination of enrollment.
- “Sec. 2204. Requirement of health insurance coverage.

“PART B—HEALTH INSURANCE BENEFITS

- “Sec. 2211. Required health services.

“PART C—PAYMENTS FOR BENEFITS; DEDUCTIBLES, COINSURANCE, AND STOP-LOSS PROTECTION FOR REQUIRED HEALTH SERVICES

- “Sec. 2221. Payments for benefits.
- “Sec. 2222. Deductible for required health services.
- “Sec. 2223. Coinsurance for required health services.
- “Sec. 2224. Limit on cost-sharing for required health services.
- “Sec. 2225. Exclusions; coordination.
- “Sec. 2226. Application of particular qualified health plan requirements.

“PART D—PREMIUMS, PUBLIC HEALTH TRUST FUND

- “Sec. 2231. Premiums.
- “Sec. 2232. Collection of premiums.
- “Sec. 2233. Public Health Trust Fund.
- “Sec. 2234. Transfer payments in the case of multiple employers.
- “Sec. 2235. Use of uniform claims forms; uniform information reporting.

“PART E—ASSISTANCE FOR LOW-INCOME INDIVIDUALS

- “Sec. 2241. Assistance for individuals with income below the poverty line enrolled on a non-employment basis.
- “Sec. 2242. Assistance for individuals with income below twice the poverty line enrolled on a non-employment basis.
- “Sec. 2243. Assistance for individuals covered under qualified employer health plans.
- “Sec. 2244. Applications for assistance.
- “Sec. 2245. Reconciliation of premium assistance through use of income statements.
- “Sec. 2246. Treatment of certain cash assistance recipients.
- “Sec. 2247. Computation of family adjusted total income.

“PART F—ADMINISTRATIVE PROVISIONS

- “Sec. 2261. Agreements with hospitals; participating physicians; treatment of Indian Health Service facilities.
- “Sec. 2262. Health maintenance organizations.
- “Sec. 2263. Use of fiscal agents.
- “Sec. 2264. General administration.
- “Sec. 2265. Determinations; appeals; Provider Reimbursement Review Board.
- “Sec. 2266. Program integrity; miscellaneous provisions.
- “Sec. 2267. Information by telephone.
- “Sec. 2268. Demonstration project authority.

“Sec. 2269. Incorporation of miscellaneous medicare provisions.

“PART G—[RESERVED]

“PART H—DEFINITIONS AND MISCELLANEOUS

“Sec. 2281. Incorporation of certain definitions used in other health-related titles.

“Sec. 2282. Definitions relating to families.

“Sec. 2283. Other definitions.

“Sec. 2284. Authorizing reciprocal coverage of foreign nationals.

“Sec. 2285. Nonapplication to residents of Puerto Rico and territories.

TITLE III—COST CONTAINMENT

Subtitle A—Health Care Spending Amounts

Sec. 301. Specification of overall health care spending amounts.

Sec. 302. Establishment of Federal Health Care Cost Containment Commission.

Sec. 303. State Health Rate Commissions.

Sec. 304. Standard for payment rates.

Sec. 305. Application of rates under medicare and public programs.

Subtitle B—Administrative Simplification

Sec. 321. Requirement for uniform health claims cards.

Sec. 322. Requirement for entitlement verification system.

Sec. 323. Requirements for uniform claims and electronic claims data set.

Sec. 324. Electronic medical records and reporting.

Sec. 325. Uniform hospital cost reporting.

Sec. 326. Definitions.

Subtitle C—Malpractice Reform

Sec. 331. Malpractice reform.

TITLE IV—GROUP HEALTH INSURANCE REFORM

Sec. 401. Excise tax on premiums received on health insurance policies which do not meet certain requirements.

Sec. 402. Group health insurance standards.

“TITLE XXIII—GROUP HEALTH INSURANCE STANDARDS

“PART 1—GENERAL STANDARDS; DEFINITIONS

“Sec. 2301. Application of requirements to employment-related health plans.

“Sec. 2302. Establishment of standards.

“Sec. 2303. Requirements applicable to all employment-related health plans.

“Sec. 2304. Definitions.

“Sec. 2305. Notice of plans meetings requirements.

“PART 2—SMALL EMPLOYER HEALTH INSURANCE REFORM

“Sec. 2311. Enrollment practice and guaranteed renewability requirements for small employer health plans.

- “Sec. 2312. Rating practices for small employer health plans.
- “Sec. 2313. Basic benefit package for small employer health plans.
- “Sec. 2314. Miscellaneous disclosure and record-keeping requirements for small employer health plans.
- “Sec. 2315. Payment of commissions.
- “Sec. 2316. Nonapplication in Puerto Rico and the territories.

TITLE V—CHANGES IN MEDICARE PROGRAM

- Sec. 501. Coverage of colorectal screening.
- Sec. 502. Coverage of certain immunizations.
- Sec. 503. Coverage of well-child care.
- Sec. 504. Annual screening mammography.
- Sec. 505. Demonstration projects for coverage of other preventive services.
- Sec. 506. OTA study of process for review of medicare coverage of preventive services.
- Sec. 507. Phased-in requirement of part B enrollment.
- Sec. 508. Changes in participation agreements.
- Sec. 509. Assuring coordination of enrollment with qualified health plans.

TITLE VI—FINANCING PROVISIONS

Subtitle A—General Provisions

- Sec. 601. Increase in wage base for hospital insurance tax.

Subtitle B—Deductibility of Certain Health Insurance Costs

- Sec. 611. Indefinite extension of deduction for health insurance costs of self-employed individuals.
- Sec. 612. Increase in amount of deduction for self-employed individuals.
- Sec. 613. Deduction for premiums paid by small employers for insurance providing qualified health coverage.

Subtitle C—State Maintenance of Effort

- Sec. 621. State maintenance of effort.

TITLE VII—MEDICAID PROVISIONS

- Sec. 701. Coordination with public health plan.

1 **TITLE I—REQUIRING EMPLOY-**
2 **ERS TO PROVIDE HEALTH IN-**
3 **SURANCE COVERAGE FOR**
4 **EMPLOYEES AND DEPEND-**
5 **ENTS**

6 **SEC. 101. REQUIREMENT.**

7 (a) IN GENERAL.—Chapter 47 of the Internal Reve-
8 nue Code of 1986 is amended by adding at the end thereof
9 the following new section:

10 **“SEC. 5000A. FAILURE TO COVER EMPLOYEES AND DE-**
11 **PENDENTS UNDER A QUALIFIED EMPLOYER**
12 **HEALTH PLAN.**

13 “(a) IMPOSITION OF TAX.—In addition to other
14 taxes, if an employee of any employer is not covered under
15 a qualified employer health plan of such employer, there
16 is hereby imposed on such employer a tax.

17 “(b) AMOUNT OF TAX.—

18 “(1) IN GENERAL.—The amount of the tax im-
19 posed by subsection (a) on any failure with respect
20 to an employee shall be \$100 for each day in the
21 noncompliance period with respect to such failure.

22 “(2) NONCOMPLIANCE PERIOD.—For purposes
23 of this section, the term ‘noncompliance period’
24 means, with respect to any failure, the period—

1 “(A) beginning on the date such failure
2 first occurs, and

3 “(B) ending on the date such failure is
4 corrected.

5 “(c) LIABILITY FOR TAX.—The employer shall be lia-
6 ble for the tax imposed by subsection (a).

7 “(d) EXCEPTIONS.—

8 “(1) TRANSITION.—The taxes imposed by this
9 section shall not take effect before the date on which
10 the requirements of part A of title XXI of the Social
11 Security Act apply with respect to the employer
12 under section 2105(a) of such Act.

13 “(2) EMPLOYEES COVERED BY FEDERAL
14 HEALTH PLAN.—The taxes imposed by this section
15 shall not apply to any employee of the United States
16 if, by reason of such employment (or the employ-
17 ment of a family member), the employee—

18 “(A) is enrolled in a health benefits plan
19 under chapter 89 of title 5, United States Code,
20 or

21 “(B) is provided medical and dental bene-
22 fits under chapter 55 of title 10 of such Code.

23 “(3) TAX NOT TO APPLY WHERE FAILURE NOT
24 DISCOVERED EXERCISING REASONABLE DILI-
25 GENCE.—No tax shall be imposed by subsection (a)

1 on any failure during any period for which it is es-
2 tablished to the satisfaction of the Secretary that the
3 employer did not know, and exercising reasonable
4 diligence would not have known, that such failure
5 existed.

6 “(4) TAX NOT TO APPLY TO FAILURE COR-
7 RECTED WITHIN 30 DAYS.—No tax shall be imposed
8 by subsection (a) on any failure if—

9 “(A) such failure was due to reasonable
10 cause and not to willful neglect, and

11 “(B) such failure is corrected during the
12 first 30 days of the noncompliance period with
13 respect to such failure.

14 “(5) WAIVER BY SECRETARY.—In the case of a
15 failure which is due to reasonable cause and not to
16 willful neglect, the Secretary may waive part of all
17 of the tax imposed by subsection (a) to the extent
18 that the payment of such tax would be unduly bur-
19 densome relative to the failure involved.

20 “(e) DEFINITIONS.—For purposes of this section—

21 “(1) EMPLOYEE; EMPLOYER.—The terms ‘em-
22 ployee’ and ‘employer’ have the same meanings as
23 such terms have for purposes of chapter 21.

24 “(2) QUALIFIED EMPLOYER HEALTH PLAN.—
25 The term ‘qualified employer health plan’ means a

1 plan meeting the requirements of title XXI of the
2 Social Security Act.

3 “(3) COVERED.—An employee is not considered
4 to be ‘covered’ under a qualified employer health
5 plan if a dependent of the employee, whose coverage
6 is provided for under title XXI of the Social Security
7 Act, is not covered under such plan.”.

8 (b) DEFICIENCY PROCEDURES TO APPLY TO CHAP-
9 TER 47.—

10 (1) The following provisions of the Internal
11 Revenue Code of 1986 are each amended by striking
12 “or 44” each place it appears and inserting “44, or
13 47”.

14 (A) Subsections (a) and (b)(2) of section
15 6211.

16 (B) Section 6212(a).

17 (C) Subsections (a) and (g) of section
18 6213.

19 (D) Subsections (c) and (d) of section
20 6214.

21 (E) Section 6161(b)(1).

22 (F) Section 6344(a)(1).

23 (G) Subsections (a) and (b)(1) of section
24 6512.

25 (H) Section 7422(e).

1 (2) Sections 6211(a) and 6862(a) of such Code
 2 are each amended by striking “and 44” and insert-
 3 ing “44, and 47”.

4 (3) Paragraph (1) of section 6212(b) of such
 5 Code is amended—

6 (A) by striking “or chapter 44” and insert-
 7 ing “chapter 44, or chapter 47”, and

8 (B) by striking “chapter 44, and this chap-
 9 ter” and inserting “chapter 44, chapter 47, and
 10 this chapter”.

11 (4) Paragraph (1) of section 6212(c) of such
 12 Code is amended by striking “or of chapter 44 tax
 13 for the same taxable period” and inserting “, of
 14 chapter 44 tax for the same taxable period, or of
 15 chapter 47 for each act or failure to act to which the
 16 petition relates”.

17 (c) CLERICAL AMENDMENTS.—

18 (1) So much of chapter 47 of such Code as pre-
 19 cedes subsection (a) of section 5000 is amended to
 20 read as follows:

21 **“CHAPTER 47—TAXES RELATING TO**
 22 **GROUP HEALTH PLANS**

 “Sec. 5000. Contributions to nonconforming large group health
 plans.

 “Sec. 5000A. Failure to cover employees and dependents under
 a qualified employer health plan.

1 **“SEC. 5000. CONTRIBUTIONS TO NONCONFORMING LARGE**
 2 **GROUP HEALTH PLANS.”**

3 (2) The table of chapters for subtitle D of such
 4 Code is amended by striking the item relating to
 5 chapter 47 and inserting the following:

“Chapter 47. Taxes relating to group health plans.”

6 (d) EFFECTIVE DATE.—The amendments made by
 7 this section shall apply to failures occurring after Decem-
 8 ber 31, 1993.

9 **SEC. 102. MEETING REQUIREMENT THROUGH ENROLL-**
 10 **MENT OF EMPLOYEES AND FAMILIES UNDER**
 11 **QUALIFIED EMPLOYER HEALTH PLANS.**

12 The Social Security Act is amended by adding at the
 13 end the following new title:

14 **“TITLE XXI—REQUIREMENT FOR ENROLL-**
 15 **MENT OF EMPLOYEES UNDER A QUALI-**
 16 **FIED EMPLOYER HEALTH PLAN**

17 **“SEC. 2100. RELATION TO INTERNAL REVENUE CODE RE-**
 18 **QUIREMENT.**

19 “(a) IN GENERAL.—If an employer fails to enroll em-
 20 ployees (and family members) under a qualified employer
 21 health plan in accordance with this title, the employer is
 22 liable for payment of an excise tax under section 5000A(a)
 23 of the Internal Revenue Code of 1986.

24 “(b) TREATMENT OF SMALL EMPLOYERS.—A small
 25 employer may meet such requirements through purchase

1 of coverage under the public plan provided under title
2 XXII.

3 “PART A—EMPLOYER REQUIREMENT TO ENROLL EM-
4 PLOYEES AND FAMILIES IN A QUALIFIED EM-
5 PLOYER HEALTH PLAN

6 “**SEC. 2101. APPLICATION TO FULL-TIME EMPLOYEES.**

7 “(a) UNMARRIED EMPLOYEES.—

8 “(1) IN GENERAL.—Except as provided in this
9 part, each employer shall, in accordance with this
10 title, enroll each of its full-time employees who is un-
11 married in a qualified employer health plan.

12 “(2) MULTIPLE FULL-TIME EMPLOYMENT.—

13 “(A) EACH OFFERS QUALIFIED PLAN.—In
14 the case of an unmarried individual who is a
15 full-time employee of more than 1 employer, if
16 more than 1 such employer offers the employee
17 enrollment under a qualified employer health
18 plan—

19 “(i) the individual shall elect (in a
20 manner specified by the Secretary) the
21 qualified employer health plan under which
22 the individual (and family members) will
23 be enrolled;

24 “(ii) a nonenrolling employer—

1 “(I) is not obligated to enroll the
2 employee (and family members) under
3 its qualified employer health plan (if
4 any) and may not charge the individ-
5 ual any premiums for required cov-
6 erage under the qualified employer
7 health plan, and

8 “(II) is not liable for any tax
9 under section 3151(a)(1) of the Inter-
10 nal Revenue Code of 1986 but is lia-
11 ble for a nonenrolling employer pre-
12 mium under section 2234(a)(1)(A);
13 and

14 “(iii) the enrolling employer is eligible
15 for an enrolling employer subsidy under
16 section 2234(a)(1)(B).

17 “(B) ONLY 1 OFFERS QUALIFIED PLAN.—

18 In the case of an unmarried individual who is
19 a full-time employee of more than 1 employer,
20 if only 1 employer offers the employee enroll-
21 ment under a qualified employer health plan—

22 “(i) the individual shall be enrolled
23 under such plan and, pursuant to sub-
24 section (c)(2) of section 3151 of the Inter-
25 nal Revenue Code of 1986, is not subject

1 to taxes under subsection (a)(2) of such
2 section with respect to employment with
3 nonenrolling employers, and

4 “(ii) the enrolling employer is eligible
5 for an enrolling employer subsidy under
6 section 2234(a)(1)(B).

7 “(b) MARRIED EMPLOYEES.—

8 “(1) IN GENERAL.—Except as provided in this
9 part, each employer shall, in accordance with this
10 title, enroll each of its full-time employees who is
11 married in a qualified employer health plan.

12 “(2) BOTH FULL-TIME EMPLOYEES.—In the
13 case of married individuals, if both are full-time em-
14 ployees of 1 or more employers, rules established by
15 the Secretary based on the rules under subsection
16 (a)(2) for multiple employment of unmarried individ-
17 uals shall apply.

18 “(c) CONSTRUCTION.—Nothing in this section shall
19 be construed as preventing the nonenrolling plan from
20 supplementing the benefits of the enrolling plan.

21 “(d) DEFINITIONS.—In this section, the terms ‘en-
22 rolling employer’ and ‘enrolling plan’ mean, with respect
23 to an individual or a married couple, the employer that
24 offers the qualified employer health plan in which the indi-
25 vidual or couple is enrolled under subsection (a)(2)(A)(i)

1 or (b)(2)(A)(i) and such plan, respectively, and the terms
2 ‘nonenrolling employer’ and ‘nonenrolling plan’ mean the
3 other employer and other qualified employer health plan,
4 respectively.

5 **“SEC. 2102. APPLICATION TO PART-TIME EMPLOYEES.**

6 “(a) APPLICATION OF FULL-TIME EMPLOYEE
7 RULES.—Subject to subsection (b), the provisions of sec-
8 tion 2101 shall apply to part-time employees in the same
9 manner as they apply to full-time employees.

10 “(b) SEPARATE TREATMENT OF PART-TIME AND
11 FULL-TIME EMPLOYEES UNDER QUALIFIED EMPLOYER
12 HEALTH PLANS.—For rule regarding separate, but uni-
13 form, treatment of full-time and part-time employees (and
14 family members), see section 2104(b).

15 **“SEC. 2103. APPLICATION TO SEASONAL AND TEMPORARY**
16 **EMPLOYEES.**

17 “(a) ENROLLMENT UNDER QUALIFIED EMPLOYER
18 HEALTH PLAN NOT AFFECTING APPLICATION OF EXCISE
19 TAX.—The enrolling by an employer of an employee des-
20 ignated under subsection (b) as a seasonal or temporary
21 employee (as defined in section 2181(b)(3)), whether a
22 part-time or full-time employee, under the qualified em-
23 ployer health plan of the employer shall not be considered,
24 for purposes of section 3151 of the Internal Revenue Code

1 of 1986, coverage of the employee under a qualified em-
2 ployer health plan.

3 “(b) DESIGNATION OF SEASONAL OR TEMPORARY
4 EMPLOYEES.—Each employer shall designate, at the time
5 of initial employment and in a manner specified by the
6 Secretary, if the individual is to be treated under this title
7 and title XXII as a seasonal or temporary employee.

8 **“SEC. 2104. TREATMENT OF ALL FAMILY MEMBERS AS A**
9 **UNIT; UNIFORM TREATMENT OF FULL-TIME**
10 **EMPLOYEES AND OF PART-TIME EMPLOYEES.**

11 “(a) TREATMENT OF ALL FAMILY MEMBERS AS A
12 UNIT.—

13 “(1) IN GENERAL.—In accordance with section
14 2152(a), enrollment of an employee in a qualified
15 employer health plan shall include enrollment of the
16 other family members of the employee.

17 “(2) TREATMENT OF CHILDREN.—In the case
18 of an individual who is a child, the employer of the
19 child is not required to enroll the child in a qualified
20 employer health plan by virtue of the part-time or
21 full-time employment of the child (whether or not
22 the parent of the child is a full-time or part-time
23 employee). However, the employer is liable for taxes
24 under section 3151(a)(1) of the Internal Revenue
25 Code of 1986 (or payment of a nonenrolling em-

1 employer premium under section 2234(a)(1)(A)) with
2 respect to such employment, and the child is, subject
3 to section 3151(c)(2) of such Code, liable for taxes
4 under section 3151(a)(2) of such Code.

5 “(b) UNIFORM TREATMENT OF FULL-TIME EMPLOY-
6 EES AND OF PART-TIME EMPLOYEES.—Except as author-
7 ized under sections 2101 and 2102 (with respect to per-
8 mitting certain multiple-employed individuals to elect cov-
9 erage under qualified employer health plans) and as pro-
10 vided under section 2103 and subsection (a)(2) of this sec-
11 tion, an employer health plan is not a qualified employer
12 health plan if the plan—

13 “(1) enrolls some (but not all) full-time employ-
14 ees (and family members) required to be enrolled
15 under this part, or

16 “(2) enrolls some (but not all) part-time em-
17 ployees (and family members) required to be enrolled
18 under this part.

19 However, a plan may be a qualified employer health plan
20 and enroll only full-time employees (and family members),
21 but not part-time employees (and family members).

22 **“SEC. 2105. APPLICATION OF REQUIREMENT TO EMPLOY-**
23 **ERS OF DIFFERENT SIZES.**

24 “(a) IN GENERAL.—Except as provided in subsection
25 (b), the requirements of this part apply—

1 “(1) as of January 1, 1994, to very large em-
2 ployers;

3 “(2) as of January 1, 1995, to large employers;

4 “(3) as of January 1, 1996, to medium-size em-
5 ployers; and

6 “(4) as of January 1, 1997, to small employers.

7 “(b) TRANSITION FOR COLLECTIVE BARGAINING
8 AGREEMENTS.—The requirements of this part shall not
9 apply to employers with respect to their employees, insofar
10 as such employees are covered under a collective bargain-
11 ing agreement ratified before the date of the enactment
12 of this title, earlier than the date of termination of such
13 agreement (determined without regard to any extension
14 thereof agreed to after the date of the enactment of this
15 title).

16 **“SEC. 2106. TIMING OF ENROLLMENT; PERIOD OF COV-**
17 **ERAGE.**

18 “(a) TIMING OF ENROLLMENT; NOTICES.—

19 “(1) IN GENERAL.—Enrollment under this part
20 shall occur not later than the date on which the em-
21 ployment, for which such enrollment is required
22 under this part, commences.

23 “(2) REFERENCE TO DISCLOSURE REQUIRE-
24 MENT.—For requirement for disclosure to employees
25 of information respecting the availability of low-in-

1 come assistance under part E of title XXII, see sec-
2 tion 2158(a)(1).

3 “(b) PERIOD OF COVERAGE.—

4 “(1) BEGINNING OF COVERAGE.—Coverage
5 under a qualified employer health plan shall begin in
6 accordance with section 2152(b).

7 “(2) TERMINATION OF COVERAGE.—

8 “(A) IN GENERAL.—If an enrollment is ef-
9 fected under this part on the basis of employ-
10 ment, coverage under such enrollment may be
11 terminated, subject to subparagraph (B), on the
12 last day of the month (or of any subsequent
13 month) during which such employment is termi-
14 nated.

15 “(B) NOTICE REQUIRED.—Effective on the
16 date specified in section 2157(b)(2), coverage
17 under a qualified employer health plan shall not
18 be terminated unless notice has been provided
19 to the Secretary, as required in section
20 2157(b)(1), of such termination at least 7 days
21 before the last day of the month in which em-
22 ployment is terminated (or any subsequent
23 month).

24 “(3) TREATMENT OF FAMILY MEMBERS.—Sub-
25 ject to section 2152, the period of coverage for fam-

3 “PART B—REQUIREMENTS FOR QUALIFIED EMPLOYER
4 HEALTH PLANS

6 “(a) IN GENERAL.—In this title and title XXII, sub-
7 ject to subsection (b), the term ‘qualified employer health
8 plan’ means an employment-related health plan (as de-
9 fined in section 2304(a)(2)) that—

“(2) except as provided in section 2122, does not impose premiums, deductibles, or copayments on employees (and family members) required to be enrolled in a qualified employer health plan under part A, and

20 “(b) TYPES OF QUALIFIED EMPLOYER HEALTH
21 PLANS.—

22 “(1) LARGE EMPLOYERS.—A very large or
23 large employer may meet the requirements of this
24 title through a qualified employer health plan that is
25 an insured plan or that is a self-insured plan.

1 “(2) MEDIUM-SIZE AND SMALL EMPLOYERS.—
2 A medium-size or small employer may meet the re-
3 quirements of this title only through a qualified em-
4 ployer health plan that is an insured plan or through
5 the public health plan under title XXII.

6 “(3) INSURED PLAN DEFINED.—The term ‘in-
7 sured plan’ has the meaning given the term ‘applica-
8 ble accident and health insurance contract’ in sec-
9 tion 5000B(e)(1) of the Internal Revenue Code of
10 1986.

11 **“SEC. 2122. REQUIREMENTS RELATING TO EMPLOYEE PRE-**
12 **MIUMS AND COST-SHARING.**

13 “(a) ENROLLEE PREMIUMS AND COST-SHARING
14 PERMITTED.—

15 “(1) IN GENERAL.—A qualified employer health
16 plan may require an enrollee to pay for—

17 “(A) premiums for coverage under the
18 plan, but only if the premiums do not exceed
19 the limitations imposed under this section, and

20 “(B) cost-sharing amounts for coverage
21 under the plan, but only if the cost-sharing does
22 not exceed the limitations on deductibles,
23 copayments, and coinsurance imposed with re-
24 spect to qualified health plans under section
25 2155.

1 “(2) TREATMENT OF ADDITIONAL, REQUIRED
2 COVERAGE.—If a qualified employer health plan pro-
3 vides benefits in addition to the benefits required
4 under this title and the employee is not permitted
5 the option of not accepting such additional benefits,
6 the plan—

7 “(A) may not impose a premium, for such
8 required and additional benefits, that exceeds
9 the premiums that may be imposed for the
10 basic benefits, and

11 “(B) shall assure that cost-sharing is not
12 imposed with respect to required health services
13 once the cost-sharing limit has been reached in
14 a year with respect to benefits for such services.

15 “(3) NONDISCRIMINATION IN PREMIUM
16 AMOUNTS.—Under a qualified employer health plan,
17 no employee may be charged a different premium for
18 similar benefits in the same employer health plan for
19 the same beneficiary class based on the age or sex
20 of the employee.

21 “(b) LIMITATION ON PREMIUMS.—

22 “(1) MONTHLY PREMIUM LIMITED TO 20 PER-
23 CENT OF ACTUARIAL RATE.—

1 “(A) IN GENERAL.—A qualified employer
2 health plan may not require an employee to pay
3 a premium—

4 “(i) for coverage for a period of longer
5 than one month, or

6 “(ii) the amount of which on a month-
7 ly basis exceeds 20 percent of the monthly
8 actuarial rate (as defined under subpara-
9 graph (B)).

10 “(B) MONTHLY ACTUARIAL RATE DE-
11 FINED.—For purposes of this subsection, the
12 term ‘monthly actuarial rate’ means, with re-
13 spect to a qualified employer health plan in a
14 plan year, the average monthly per enrollee
15 amount that the plan estimates, for enrollees
16 under the plan during the year, would be nec-
17 essary to pay for the total benefits required
18 during the year under the plan (with respect to
19 required health services), including admin-
20 istrative costs for the provision of such benefits
21 and an appropriate amount for a contingency
22 margin.

23 “(C) APPLICATION ON BASIS OF FAMILY
24 STATUS.—For purposes of subparagraph (B), a
25 qualified employer health plan may provide for

1 the premium to be applied, and the monthly ac-
2 tuarial rate described in such subparagraph to
3 be estimated, for required health services based
4 on the beneficiary classes described in section
5 2231(d)(1) or on such other beneficiary classi-
6 fications, consistent with subsection (a), as the
7 employer or plan may specify.

8 “(3) LIABILITY FOR PAYMENT OF PREMIUMS.—

9 An employee enrolled under a qualified employer
10 health plan is liable for payment of premiums re-
11 quired under that plan in accordance with this sub-
12 section. In no case shall an employee be liable for
13 premiums with respect to a qualified employer
14 health plan, other than the portion of the premium
15 which may be imposed on the employee consistent
16 with this section.

17 “(4) WITHHOLDING PERMITTED.—No provision

18 of State law shall prevent an employer of an em-
19 ployee enrolled under a qualified employer health
20 plan from withholding the amount of any premium
21 due by the employee under this subsection from the
22 wages paid the employee.

23 “(5) CONSTRUCTION.—Nothing in this section

24 shall be construed—

1 “(A) as preventing an employer from pay-
2 ing part or all of the employee premium for re-
3 quired health services or other health services,
4 or

5 “(B) subject to subsection (a), from re-
6 quiring an employee to pay for all or part of the
7 premium for benefits for services other than re-
8 quired health services.

9 “PART C—STANDARDS FOR QUALIFIED HEALTH PLANS

10 **“SEC. 2151. CERTIFICATION OF QUALIFIED HEALTH PLANS.**

11 “(a) QUALIFIED HEALTH PLAN DEFINED.—For
12 purposes of this title, the term ‘qualified health plan’
13 means a health plan that the Secretary certifies, upon ap-
14 plication by the plan, to meet the requirements of this
15 part.

16 “(b) REVIEW AND RECERTIFICATION.—The Sec-
17 retary shall establish procedures for the periodic review
18 and recertification of plans as qualified health plans.

19 “(c) TERMINATION OF CERTIFICATION.—The Sec-
20 retary shall terminate the certification of a qualified
21 health plan if the Secretary determines that the plan no
22 longer meets the requirements for certification. Before
23 effecting a termination, the Secretary shall provide the
24 plan notice and opportunity for a hearing on the proposed
25 termination.

1 **“SEC. 2152. TREATMENT OF FAMILY AS A UNIT; COVERAGE**
2 **PERIOD; HEALTH PLAN CARDS.**

3 “(a) TREATMENT OF FAMILY AS A UNIT.—

4 “(1) IN GENERAL.—Subject to paragraph (2),
5 enrollment of an individual in a qualified health plan
6 shall include enrollment of the other family members
7 (as defined in section 2282(1)) of the individual.

8 “(2) TREATMENT OF INELIGIBLE INDIVID-
9 UALS.—Nothing in paragraph (1) shall be construed
10 as requiring a qualified health plan (or permitting
11 the public health plan) to enroll individuals who are
12 not eligible individuals (as defined in section
13 2201(d)).

14 “(b) BEGINNING OF COVERAGE.—

15 “(1) IN GENERAL.—In the case of an individual
16 enrolled under any qualified health plan, subject to
17 subsection (c), the benefits under the plan shall first
18 become available for services furnished beginning on
19 the first day of the month following the month of
20 enrollment.

21 “(2) SPECIAL RULES.—The Secretary shall pro-
22 vide for such standards as may be necessary to pro-
23 vide for the allocation of responsibility among quali-
24 fied health plans (including the public health plan
25 under title XXII) in the case of an inpatient hospital
26 stay, or in the case in which a single payment

1 amount if made for other services provided over a
2 period of time, that begins during the period of cov-
3 erage under one qualified health plan and ends dur-
4 ing a period of coverage under another qualified
5 health plan.

6 “(c) STANDARDS TO REFLECT CHANGES IN FAMILY
7 AND EMPLOYMENT STATUS.—

8 “(1) IN GENERAL.—Under standards estab-
9 lished by the Secretary consistent with this sub-
10 section, qualified health plans shall provide for ap-
11 propriate changes in the coverage of family members
12 to take into account—

13 “(A) changes in family composition or sta-
14 tus, including marriage, divorce (or legal sepa-
15 ration), birth or adoption of children, and the
16 aging of children into adulthood, and

17 “(B) changes in employment status.

18 “(2) MONTHLY CHANGES.—Except as specifi-
19 cally provided in this subsection, such standards
20 shall be designed—

21 “(A) to effect a change in enrollment (or
22 status of enrollment) as of the first day of the
23 first month (or, in order to provide for notice
24 and an opportunity for coordination among

1 plans, a later month) following the date of the
2 event causing the change,

3 “(B) to prevent any periods of noncoverage
4 under any qualified health plans, and

5 “(C) to provide, in the case of a change of
6 family status such as marriage, divorce, or legal
7 separation, for accounting and crediting of cost-
8 sharing among family members (described in
9 section 2157(c)) in an equitable and admin-
10 istrable manner.

11 “(3) TREATMENT OF NEWBORNS.—

12 “(A) BIRTH TO WOMAN DURING PERIOD
13 OF COVERAGE.—Any child born to a woman
14 during the period of coverage under a qualified
15 health plan shall, as of the date of birth, be
16 automatically enrolled and covered for benefits
17 under the plan.

18 “(B) BIRTH TO WOMAN WITHOUT COV-
19 ERAGE.—Any child born in the United States to
20 a woman who is not, at the time of birth, en-
21 rolled under a qualified health plan shall be
22 automatically enrolled and covered for benefits
23 under this title as of the date of birth if an ap-
24 plication for such enrollment is made not later

1 than 60 days after the date of birth or, if later,
2 the end of the year in which the child is born.

3 “(4) ADOPTION.—

4 “(i) TREATMENT OF VOLUNTARY RELIN-
5 QUISHMENT.—Any child who is voluntarily re-
6 linquished to a public or private agency shall,
7 upon the application by the agency, be enrolled
8 under this title and covered as of the date of
9 the relinquishment, until the date of the child’s
10 placement for adoption.

11 “(ii) TREATMENT OF ADOPTED CHIL-
12 DREN.—Any child who is placed for adoption
13 with an individual during the period the individ-
14 ual is enrolled and covered under a qualified
15 health plan shall, as of the date of the place-
16 ment for adoption, be treated as the child of the
17 individual and be automatically enrolled and
18 covered under such plan.

19 “(5) PLACEMENT IN CUSTODY OF PUBLIC
20 AGENCY PURSUANT TO COURT ORDER OR OTHER-
21 WISE.—Any child who is removed from the family
22 and placed in the temporary custody of a public
23 agency pursuant to a court order or otherwise shall,
24 upon application by the public agency on or after the
25 date of the removal and placement with the public

1 agency, be deemed to be automatically enrolled and
2 covered for benefits under this title as of the date
3 of the application, until the child is returned to the
4 family or placed for adoption.

5 “(6) TREATMENT OF LEGAL WARDS, FOSTER
6 CHILDREN, ETC.—In cases not described in para-
7 graphs (4) or (5), the Secretary shall establish
8 standards relating to the time an individual de-
9 scribed in section 2282(5)(B)(ii) is treated as the
10 child of the person with custody and such other
11 standards as may be necessary to assure the proper
12 coordination of enrollment of children and other in-
13 dividuals among qualified health plans.

14 “(d) HEALTH PLAN CARDS.—In conjunction with en-
15 rollment of individuals under a qualified health plan, the
16 plan shall provide for the issuance of a card which may
17 be used for purposes of identification of such enrollment
18 and the processing of claims for benefits under the plan.
19 Such card shall—

20 “(1) identify (as appropriate) the types of bene-
21 fits to which the individual is entitled under the
22 plan, and

23 “(2) contain such other information as the Sec-
24 retary (and the plan) shall specify.

1 **“SEC. 2153. REQUIREMENTS RESPECTING BASIC BENEFITS.**

2 “(a) IN GENERAL.—Each qualified health plan must
3 provide for benefits for at least all required health services
4 (as defined in section 2211(a)(2)).

5 “(b) TREATMENT OF ADDITIONAL BENEFITS.—
6 Nothing in this section shall be construed as preventing
7 a qualified health plan from including benefits in addition
8 to benefits for required health services.

9 **“SEC. 2154. REQUIREMENTS RESPECTING LIMITS ON PRE-**
10 **EXISTING CONDITION EXCLUSIONS AND COV-**
11 **ERAGE STANDARDS FOR BASIC HEALTH**
12 **SERVICES.**

13 “(a) IN GENERAL.—Except as provided under sub-
14 section (b), a qualified health plan—

15 “(1) may not deny, limit, or condition the cov-
16 erage under (or benefits of) the plan with respect to
17 basic health services based on the health status,
18 claims experience, receipt of health care, medical his-
19 tory, or lack of evidence of insurability, of an indi-
20 vidual, and

21 “(2) may not provide for exclusions from cov-
22 erage for basic health services that are more restric-
23 tive than the exclusions for such services under this
24 title.

25 “(b) TREATMENT OF PRE-EXISTING CONDITION EX-
26 CLUSIONS FOR ALL SERVICES.—

1 “(1) IN GENERAL.—Subject to the succeeding
2 provisions of this subsection, a qualified health plan
3 (other than the public health plan) may exclude cov-
4 erage with respect to services related to treatment of
5 a pre-existing condition, but the period of such ex-
6 clusion may not exceed 6 months.

7 “(2) NONAPPLICATION TO NEWBORNS AND
8 SUNSET OF PRE-EXISTING CONDITION EXCLUSIONS
9 FOR BASIC HEALTH SERVICES.—The exclusion of
10 coverage permitted under paragraph (1) shall not
11 apply to—

12 “(A) services furnished to newborns, or

13 “(B) basic health services furnished on or
14 after July 1 of the 4th year beginning after the
15 date of the enactment of this title.

16 “(3) CREDITING OF PREVIOUS COVERAGE.—

17 “(A) IN GENERAL.—If an individual is in
18 a period of continuous coverage (as defined in
19 subparagraph (B)(i)) with respect to particular
20 services as of the date of initial coverage under
21 a plan, any period of exclusion of coverage with
22 respect to a pre-existing condition for such serv-
23 ices or type of services shall be reduced by 1
24 month for each month in the period of continu-
25 ous coverage.

1 “(B) DEFINITIONS.—In this paragraph:

2 “(i) PERIOD OF CONTINUOUS COV-
3 ERAGE.—The term ‘period of continuous
4 coverage’ means, with respect to particular
5 services, the period beginning on the date
6 an individual is enrolled under a health
7 plan or program (including a qualified
8 health plan, a Federal health plan, the
9 medicare program, a State plan under title
10 XIX, or a State general medical assistance
11 program) which provides the same or sub-
12 stantially similar benefits with respect to
13 such services and ends on the date the in-
14 dividual is not so enrolled for a continuous
15 period of more than 3 months.

16 “(ii) PRE-EXISTING CONDITION.—The
17 term ‘pre-existing condition’ means, with
18 respect to coverage under a plan, a condi-
19 tion which has been diagnosed or treated
20 during the 3-month period ending on the
21 day before the first date of such coverage,
22 except that such term does not include a
23 condition which was first diagnosed or
24 treated during a period of continuous
25 coverage.

1 “(C) STANDARDS FOR SIMILAR BENE-
2 FITS.—The Secretary shall establish such cri-
3 teria for determining if benefits are substan-
4 tially similar as may be necessary to carry out
5 this subsection.

6 **“SEC. 2155. REQUIREMENTS RESPECTING LIMITS ON COST-**
7 **SHARING.**

8 “(a) IN GENERAL.—A qualified health plan may not
9 impose deductibles, copayments, or coinsurance with re-
10 spect to required health services in excess of the deductible
11 and coinsurance permitted under part C of title XXII with
12 respect to such services (not taking into account any low-
13 income assistance provided under part E of title XXII).

14 “(b) CONSTRUCTION.—Nothing in this section shall
15 be construed as preventing a qualified health plan from
16 providing for deductibles, coinsurance, and copayments or
17 other restrictions with respect to services other than re-
18 quired health services that are different from those per-
19 mitted with respect to required health services.

20 **“SEC. 2156. USE OF PAYMENT RATES.**

21 “A qualified health plan shall establish adequate pay-
22 ment rates for required health services using the payment
23 rates approved under title III of the Health Insurance
24 Coverage and Cost Containment Act of 1993.

1 **“SEC. 2157. COORDINATION AND PORTABILITY OF HEALTH**
2 **COVERAGE UNDER QUALIFIED HEALTH**
3 **PLANS.**

4 “(a) IN GENERAL.—Each qualified health plan shall
5 provide for coordination of—

6 “(1) enrollment and termination of enrollment
7 among the qualified health plans, the public health
8 plan, and title XVIII, and

9 “(2) application of deductibles and limitations
10 on cost-sharing among such plans,
11 in accordance with standards established by the Secretary
12 consistent with this section.

13 “(b) REQUIREMENT OF NOTICES WITH RESPECT TO
14 COVERAGE.—

15 “(1) IN GENERAL.—Each qualified health plan
16 shall provide notice at the time an individual’s cov-
17 erage under the plan begins or is terminated. Such
18 notice shall be provided (in a form and manner and
19 at a time specified by the Secretary)—

20 “(A) to the individual (or in the case of en-
21 rollment only of a child or children, to the par-
22 ent enrolling the child or children), and

23 “(B) effective (on the date specified in
24 paragraph (2)) to the Secretary.

1 The notice under this paragraph shall include the
2 names and other identifying information of family
3 members whose coverage is affected by the change.

4 “(2) DATE OF REQUIREMENT FOR NOTICE TO
5 PUBLIC HEALTH PLAN.—The date specified in this
6 paragraph is January 1, 1994, or, with respect to a
7 qualified employer health plan of an employer, the
8 date the requirements of part A apply with respect
9 to the employer under section 2105(a).

10 “(3) NOTICE TO BENEFICIARY AND OTHER
11 QUALIFIED HEALTH PLANS UPON OBTAINING COV-
12 ERAGE.—In the case of an individual who begins
13 coverage under a qualified employer health plan (or
14 under this title on an employment basis), when the
15 Secretary receives notice under paragraph (1)(B)—

16 “(A) if, at the time of obtaining such cov-
17 erage, the individual is enrolled on a non-em-
18 ployment basis in the public health plan, the
19 Secretary shall notify the individual that cov-
20 erage for such services on such a basis or for
21 such benefits shall be terminated effective on
22 the date of coverage under such a plan, and

23 “(B) the Secretary shall provide for notice
24 to any other qualified health plan in which the

1 Secretary knows the individual is enrolled of the
2 fact of such new coverage.

3 “(4) NOTICES OF TERMINATION.—Each notice
4 of termination under paragraph (1) shall include—

5 “(A) the effective date of the termination,

6 “(B) in the case of notice to the Secretary,
7 sufficient information to permit enrollment of
8 the individuals affected under the public health
9 plan, and

10 “(C) in the case of an individual whose
11 coverage under the plan is terminated other
12 than at the end of a calendar year, the account-
13 ing statement produced under subsection (c)(2).

14 “(c) ACCOUNTING FOR COST-SHARING.—

15 “(1) IN GENERAL.—Each qualified health plan
16 shall provide for an ongoing accounting, for each en-
17 rollee (and enrolled family members) on a calendar
18 year basis, of expenses incurred for required health
19 services that are counted towards the deductible es-
20 tablished under section 2222 and that are counted
21 towards the cost-sharing limit established under sec-
22 tion 2224. The amount credited for each account
23 shall be determined in accordance with standards es-
24 tablished by the Secretary in order to provide con-
25 sistency among qualified health plans and to pro-

1 mote portability of benefits across qualified health
2 plans.

3 “(2) STATEMENT OF ACCOUNT BALANCE.—In
4 the case of an individual whose coverage under the
5 plan is terminated other than at the end of a cal-
6 endar year, the qualified health plan shall produce
7 an accounting statement (in a uniform manner es-
8 tablished by the Secretary) of the amounts that are
9 credited under the plan towards such deductible and
10 cost-sharing limitations for the year for each enrollee
11 (and family members) involved, in accordance with
12 the accounting under paragraph (1).

13 “(3) CREDITING OF PREVIOUS EXPENSES TO-
14 WARDS DEDUCTIBLES AND COINSURANCE.—Each
15 qualified health plan shall, in the case of an individ-
16 ual who is enrolled under the plan after the begin-
17 ning of a year, credit, against the deductible and
18 cost-sharing limit for required health services under
19 its plan, the amounts previously accounted against
20 the deductible and cost-sharing limit under another
21 qualified health plan for the calendar year. The
22 credit under this subparagraph shall be based on the
23 accounting statement produced under paragraph (2).

24 “(d) COVERAGE UNDER PUBLIC HEALTH PLAN.—

1 “(1) IN GENERAL.—Except as provided in this
2 subsection, the public health plan under title XXII
3 shall enroll each eligible individual whose coverage
4 under another qualified health plan or under title
5 XVIII is terminated, effective on the date following
6 the effective date of termination of coverage under
7 such plan.

8 “(2) TREATMENT OF MEDICARE-ELIGIBLE INDIVIDUALS.—Except as provided in paragraphs (3)
9 and (4), in the case of an individual who—

11 “(A) is eligible for enrollment under part
12 B of title XVIII,

13 “(B) is not so enrolled because of enrollment under a qualified health plan, but

15 “(C) whose enrollment under such a plan
16 is terminated,

17 the Secretary shall provide, upon the effective date
18 of such termination, for enrollment of the individual
19 under such part.

20 “(3) OBTAINING ALTERNATE COVERAGE.—
21 Paragraphs (1) and (2) shall not apply if the individual provides satisfactory evidence that the individual has obtained coverage through another qualified
22 health plan or is a medicare beneficiary enrolled
23 under part B of title XVIII.

1 “(4) NO AUTOMATIC ENROLLMENT DURING
2 TRANSITION.—Paragraphs (1) and (2) shall not
3 apply to terminations occurring before January 1,
4 1997. During the period before January 1, 1997, be-
5 fore an individual described in paragraph (1) enrolls
6 under this title, the Secretary shall provide the indi-
7 vidual with a notice of the minimum enrollment pe-
8 riod required under section 2202(a)(3).

9 “(e) PROVISION OF INFORMATION ON ENROLLEES.—
10 Each qualified health plan shall provide the Secretary with
11 such information as the Secretary may require in order
12 to ascertain whether (and the amount of) any transfer
13 payments to be made under section 2234.

14 **“SEC. 2158. CONSUMER PROTECTIONS.**

15 “(a) DISCLOSURE REQUIREMENTS FOR EMPLOYER
16 PLANS.—

17 “(1) NOTICE OF AVAILABILITY OF LOW-INCOME
18 ASSISTANCE.—At the time of enrollment of an em-
19 ployee under a qualified employer health plan, the
20 plan (directly or through the employer) shall provide
21 the employee with a notice (in a form specified by
22 the Secretary) of the low-income assistance available
23 under part E of title XXII with respect to enroll-
24 ment under the plan.

1 “(2) FOR SMALL EMPLOYER PLANS.—In the
2 case of a qualified employer health plan that is of-
3 ferred to a small employer, the plan may not be is-
4 sued or sold to the employer unless the employer has
5 been provided, in addition to any information re-
6 quired to be disclosed under paragraph (1), the fol-
7 lowing information:

8 “(A) A description of the benefits covered
9 in the plan and cost-sharing required with re-
10 spect to such benefits.

11 “(B) A comparison of the benefits and
12 cost-sharing described in subparagraph (A) with
13 the benefits and cost-sharing available under
14 the public health plan (not taking into account
15 any low-income assistance under part E of title
16 XXII).

17 “(3) STANDARD FORMAT.—The disclosures
18 under paragraphs (1) and (2) shall be made in a
19 uniform format established by the Secretary.

20 “(4) VIOLATIONS.—Any entity that issues or
21 sells a qualified health plan in violation of paragraph
22 (1) or (2) is subject to a civil money penalty of an
23 amount not to exceed \$5,000 with respect to each
24 such issuance or sale. The provisions of section
25 1128A (other than the first sentence of subsection

1 (a) and other than subsection (b)) shall apply to a
2 civil money penalty under the previous sentence in
3 the same manner as such provisions apply to a pen-
4 alty or proceeding under section 1128A(a).

5 “(b) EFFECTIVE GRIEVANCE PROCEDURES.—Each
6 qualified health plan shall provide for effective procedures
7 for hearing and resolving grievances between the plan and
8 individuals enrolled under the plan.

9 “(c) RESTRICTION ON CERTAIN PHYSICIAN INCEN-
10 TIVE PLANS.—

11 “(1) IN GENERAL.—A health plan is not a
12 qualified health plan if it operates a physician incen-
13 tive plan (as defined in paragraph (2)) unless the re-
14 quirements specified in clauses (i) through (iii) of
15 section 1876(i)(8)(A) are met (in the same manner
16 as they apply to eligible organizations under section
17 1876).

18 “(2) PHYSICIAN INCENTIVE PLAN DEFINED.—
19 In this subsection, the term ‘physician incentive
20 plan’ means any compensation or other financial ar-
21 rangement between the qualified health plan and a
22 physician or physician group that may directly or in-
23 directly have the effect of reducing or limiting serv-
24 ices provided with respect to individuals enrolled
25 under the plan.

1 “(d) ENROLLEE FINANCIAL PROTECTION.—

2 “(1) SOLVENCY PROTECTION FOR INSURED
3 PLANS.—In the case of a qualified health plan that
4 is an insured plan (as defined by the Secretary) and
5 is issued in a State, in order for the plan to be cer-
6 tified under this part the Secretary must find that
7 the State has established satisfactory protection of
8 enrollees with respect to potential insolvency.

9 “(2) PROTECTION AGAINST PROVIDER
10 CLAIMS.—In the case of a failure of a qualified
11 health plan to make payments with respect to re-
12 quired health services, under standards established
13 by the Secretary, an individual who is enrolled under
14 the plan is not liable to any health care provider or
15 practitioner with respect to the provision of required
16 health services for payments in excess of the amount
17 for which the enrollee would have been liable if the
18 plan were to have made payments in a timely
19 manner.

20 **“SEC. 2159. PREEMPTION OF CERTAIN STATE AND FEDERAL**
21 **REQUIREMENTS.**

22 “(a) BENEFIT AND COVERAGE RULES.—Effective as
23 of January 1, 1994, no State shall establish or enforce
24 any law or regulation that—

1 “(1) requires the offering, as part of a qualified
2 employer health plan, of any services, category of
3 care, or services of any class or type of provider that
4 is different from the benefits required to be provided
5 under section 2153,

6 “(2) specifies the individuals to be covered
7 under a qualified employer health plan or the dura-
8 tion of such coverage, or

9 “(3) requires a right of conversion from a quali-
10 fied employer health plan to an individual qualified
11 health plan.

12 “(b) STATE DEFINED.—In this section, the term
13 ‘State’ means the 50 States and the District of Columbia.

14 **“SEC. 2160. USE OF UNIFORM CLAIMS FORMS; UNIFORM IN-**
15 **FORMATION REPORTING.**

16 “Each qualified health plan shall provide for—

17 “(1) submission of claims in accordance with
18 section 323 of the Health Insurance Coverage and
19 Cost Containment Act of 1993, and

20 “(2) reporting to the Commission of informa-
21 tion on required health services provided under the
22 plan pursuant to standards promulgated under sec-
23 tion 324 of such Act.

1 “PART D—DEFINITIONS AND MISCELLANEOUS

2 **“SEC. 2181. DEFINITIONS.**

3 “(a) WAGES, EMPLOYMENT, ETC.—In this title—

4 “(1) WAGES.—The term ‘wages’ has the mean-
5 ing given such term by section 3121(a) of the Inter-
6 nal Revenue Code of 1986 except that—

7 “(A) the modifications of subsection (b)
8 shall apply in determining whether any service
9 is employment, and

10 “(B) the applicable contribution base
11 under section 3121(x)(2) of such Code (relating
12 to hospital insurance) shall be used under sec-
13 tion 3121(a)(1) for purposes of this title.

14 “(2) EMPLOYMENT.—

15 “(A) IN GENERAL.—Except as modified in
16 subparagraph (B), the term ‘employment’ has
17 the meaning given such term by section
18 3121(b) of the Internal Revenue Code of 1986.

19 “(B) MODIFICATIONS.—The modifications
20 referred to in this paragraph are that—

21 “(i) paragraphs (5), (6), (7), (8), and
22 (9) of section 3121(b) of such Code shall
23 not apply, and

24 “(ii) subsections (r) and (w) of section
25 3121 of such Code shall not apply.

1 “(C) TREATMENT OF FEDERAL EMPLOY-
2 MENT.—In applying subparagraph (A), the
3 term ‘employment’ shall not be considered to
4 include service performed in the employ of the
5 United States if, in connection with the per-
6 formance of such service (or the service of a
7 family member), the individual—

8 “(i) is enrolled in a health benefits
9 plan under chapter 89 of title 5, United
10 States Code, or

11 “(ii) is provided medical and dental
12 benefits under chapter 55 of title 10, Unit-
13 ed States Code.

14 “(3) EMPLOYEE; EMPLOYER.—The terms ‘em-
15 ployee’ and ‘employer’ have the same meanings as
16 such terms have for purposes of chapter 21 of the
17 Internal Revenue Code of 1986.

18 “(b) DEFINITIONS RELATING TO EMPLOYEES.—In
19 this title:

20 “(1) FULL-TIME EMPLOYEE.—The term ‘full-
21 time employee’ means, with respect to an employer,
22 an employee who normally performs on a monthly
23 basis at least 17½ hours of service per week for
24 that employer.

1 “(2) PART-TIME EMPLOYEE.—The term ‘part-
2 time employee’ means, with respect to an employer,
3 an employee who is not a full-time employee.

4 “(3) SEASONAL OR TEMPORARY EMPLOYEE.—
5 The term ‘seasonal or temporary employee’ means,
6 with respect to an employer, an employee who is em-
7 ployed by the employer for not more than 4 months
8 in any 12 month period; except that the Secretary
9 may extend such period for up to 6 months in any
10 12 month period in the case of employment that is
11 sporadic, irregular, and seasonal in nature.

12 “(4) TREATMENT OF CONSULTANTS AND CON-
13 TRACTORS.—The term ‘employee’ includes an indi-
14 vidual who is a consultant or contractor of an em-
15 ployer if the Secretary determines that the consult-
16 ing arrangement or contract was entered into to
17 avoid the requirements of this title.

18 “(5) EXCLUSION OF FOREIGN EMPLOYMENT.—
19 The term ‘employee’ does not include an individ-
20 ual—

21 “(A) who is not a citizen or resident of the
22 United States with respect to service performed
23 outside the United States, or

24 “(B) who is a citizen or resident of the
25 United States with respect to services per-

1 formed outside the United States for an em-
2 ployer other than an American employer (as de-
3 fined in section 3121(h) of the Internal Reve-
4 nue Code of 1986).

5 “(c) DEFINITIONS RELATING TO SIZE OF EM-
6 PLOYER.—In this title:

7 “(1) SMALL EMPLOYER.—The term ‘small em-
8 ployer’ means, with respect to a calendar year, an
9 employer that normally employs fewer than 50 em-
10 ployees on a typical business day during the cal-
11 endar year.

12 “(2) MEDIUM-SIZE EMPLOYER.—The term ‘me-
13 dium-size employer’ means, with respect to a cal-
14 endar year, an employer that normally employs at
15 least 50, but fewer than 101, employees on a typical
16 business day during the calendar year.

17 “(3) LARGE EMPLOYER.—The term ‘large em-
18 ployer’ means, with respect to a calendar year, an
19 employer that normally employs at least 100, but
20 fewer than 250, employees on a typical business day
21 during the calendar year.

22 “(4) VERY LARGE EMPLOYER.—The term ‘very
23 large employer’ means, with respect to a calendar
24 year, an employer that normally employs at least

1 250 employees on a typical business day during the
2 calendar year.

3 “(4) APPLICATION OF CONTROLLED GROUP
4 RULES.—For purposes of determining if an em-
5 ployer is a small, medium-size, large, or very large
6 employer or the number of hours an individual is
7 normally employed with respect to an employer,
8 rules similar to the rules of subsection (b) and (c)
9 of section 414 of the Internal Revenue Code of 1986
10 shall apply.

11 “(d) INCORPORATION OF DEFINITIONS.—Except as
12 otherwise provided in this title, the terms defined in sec-
13 tion 2282 and 2283 shall apply under this title in the
14 same manner as they apply under title XXII.

15 **“SEC. 2182. NONAPPLICATION TO RESIDENTS OF PUERTO**
16 **RICO AND TERRITORIES.**

17 “The provisions of this title shall not apply with re-
18 spect to an employee who is not a resident of one of the
19 50 States or the District of Columbia.”.

20 **SEC. 103. REPEAL OF COBRA CONTINUATION REQUIRE-**
21 **MENTS.**

22 (a) INTERNAL REVENUE CODE PROVISIONS.—

23 (1) IN GENERAL.—Section 4980B of the Inter-
24 nal Revenue Code of 1986 is repealed.

1 (2) CONFORMING AMENDMENTS.—Section 414
2 of such Code is amended—

3 (A) in subsection (n)(3)(C), by striking
4 “505, and 4980B” and inserting “and 505”,
5 and

6 (B) in subsection (t)(2), by striking “505,
7 or 4980B” and inserting “or 505”.

8 (b) ERISA.—

9 (1) IN GENERAL.—Part 6 of subtitle B of title
10 I of the Employee Retirement Income Security Act
11 of 1974 is repealed.

12 (2) CONFORMING AMENDMENT.—Section
13 502(c)(1) of such Act (29 U.S.C. 1132(c)(1)) is
14 amended by striking “paragraph (1) or (4) of sec-
15 tion 606 or”.

16 (c) PUBLIC HEALTH SERVICE ACT.—Title XXII of
17 the Public Health Service Act is repealed.

18 (d) EFFECTIVE DATE.—The repeals and amend-
19 ments made by this section shall apply to health plans of
20 employers as of the date specified with respect to employ-
21 ers of that size under section 2105 of the Social Security
22 Act.

23 (e) NOTICE OF BENEFITS UNDER PUBLIC HEALTH
24 PLAN.—In the case of continuation coverage which is in
25 effect on the date of a repeal under this section but which

1 is to be discontinued after such date (and before the date
 2 required under law in effect before the date of the enact-
 3 ment of this Act) such continuation may not be discon-
 4 tinued without 30-days notice to the individual of such dis-
 5 continuation. Such notice shall include such information
 6 respecting continuation of coverage through enrollment
 7 under the public health plan under title XXII of the Social
 8 Security Act as the Secretary of Health and Human Serv-
 9 ices shall specify.

10 **TITLE II—PROVISION OF**
 11 **HEALTH INSURANCE**
 12 **THROUGH A PUBLIC HEALTH**
 13 **PLAN**

14 **SEC. 201. PUBLIC HEALTH PLAN.**

15 The Social Security Act is amended by adding after
 16 the title added by section 101 the following new title:

17 “TITLE XXII—PUBLIC HEALTH PLAN

18 “PART A—ELIGIBILITY AND ENROLLMENT

19 **“SEC. 2201. ELIGIBILITY TO ENROLL FOR HEALTH INSUR-**
 20 **ANCE BENEFITS AND TO APPLY FOR LOW-IN-**
 21 **COME ASSISTANCE.**

22 “(a) ELIGIBILITY TO ENROLL FOR HEALTH INSUR-
 23 ANCE BENEFITS.—

24 “(1) IN GENERAL.—Subject to paragraph (2),
 25 each eligible individual (as defined in subsection (d))

1 who is not a medicare beneficiary and who is not en-
2 rolled under a qualified employer health plan pursu-
3 ant to title XXI or under a Federal health plan (as
4 defined in section 2204(f)) is eligible to enroll under
5 this title for health insurance benefits.

6 “(2) ENROLLMENT BY ELECTING SMALL OR
7 MEDIUM-SIZE EMPLOYERS.—In order to meet the re-
8 quirements of title XXI, a small or medium-size em-
9 ployer may provide for the enrollment of full-time
10 employees (and family members) in the plan under
11 this title in a manner specified by the Secretary, but
12 only if—

13 “(A) the employer complies with the re-
14 quirements of section 2122 with respect to the
15 plan under this title as if the plan under this
16 title were a qualified employer health plan; and

17 “(B) provides for payment of premiums (in
18 the amounts specified in section 2231) in a
19 manner specified by the Secretary.

20 “(3) EFFECTIVE DATE.—No health insurance
21 benefits are available under this title for items and
22 services furnished before January 1, 1994, or, for
23 individuals enrolled under this title as employees (or
24 dependents) of medium-size or small employers, be-
25 fore January 1, 1996, or 1997, respectively.

1 “(b) ELIGIBILITY TO APPLY FOR LOW-INCOME AS-
2 SISTANCE.—

3 “(1) IN GENERAL.—Subject to paragraph (2),
4 each eligible individual who—

5 “(A) is enrolled in the public health plan
6 under this title, whether on a non-employment
7 basis or on an employment basis,

8 “(B) is enrolled under a qualified employer
9 health plan, or

10 “(C) is a medicare beneficiary,
11 is eligible to apply for low-income assistance under
12 part E.

13 “(2) EFFECTIVE DATE.—No low-income assist-
14 ance is available for premiums for months before
15 January 1997 or for expenses incurred for any items
16 or services furnished before January 1, 1997.

17 “(c) ENROLLMENT TERMS.—

18 “(1) ENROLLMENT UNDER TITLE ON AN EM-
19 PLOYMENT AND NON-EMPLOYMENT BASIS DE-
20 FINED.—An eligible individual is considered, for pur-
21 poses of this title, to be enrolled under this title—

22 “(A) on an ‘employment basis’ only if the
23 individual is enrolled by a small employer pur-
24 suant to the requirement of section 5000A of
25 the Internal Revenue Code of 1986, or

1 “(B) on a ‘non-employment basis’ in any
2 other case.

3 “(2) ENROLLMENT UNDER A QUALIFIED EM-
4 PLOYER HEALTH PLAN DEFINED.—An individual is
5 considered, for purposes of this title, to be ‘enrolled
6 under a qualified employer health plan’ if—

7 “(A) the individual is enrolled under a
8 qualified employer health plan (as defined in
9 section 2281(b)(8)) as an employee (or family
10 member of an employee),

11 “(B) the employer is required to provide
12 for such enrollment under part A of title XXI,
13 and

14 “(C) the amount of the employee share of
15 the premium is limited under section 2122(b).

16 “(d) ELIGIBLE INDIVIDUAL DEFINED.—In this sec-
17 tion, the term ‘eligible individual’ means an individual who
18 is—

19 “(1)(A) a citizen or national of the United
20 States, (B) an alien lawfully admitted for permanent
21 residence, or (C) an alien otherwise residing perma-
22 nently in the United States under color of law, and

23 “(2) a resident of the United States.

1 **“SEC. 2202. APPLICATION FOR ENROLLMENT.**

2 “(a) PERIOD OF APPLICATION.—Individuals eligible
3 to enroll under this title may apply to enroll at any time
4 at which they are so eligible.

5 “(b) APPLICATION PROCESS.—

6 “(1) IN GENERAL.—The filing of an application
7 for enrollment under this title shall (except as the
8 Secretary may provide) constitute enrollment under
9 this title. Such an application may be filed with the
10 Secretary by mail or at such locations as the Sec-
11 retary may specify.

12 “(2) AVAILABILITY OF APPLICATIONS.—The
13 Secretary shall make applications for enrollment
14 under this title available—

15 “(A) at local offices of the Social Security
16 Administration,

17 “(B) at out-reach sites (such as provider
18 and practitioner locations), and

19 “(C) at other locations (including post of-
20 fices) accessible to a broad cross-section of indi-
21 viduals eligible to enroll.

22 “(3) APPLICATION FOR LOW-INCOME ASSIST-
23 ANCE.—An application for enrollment under this
24 section may (but need not) be accompanied by an
25 application for low-income assistance under part E.

1 “(4) RESTRICTION ON USE OF AGENTS.—The
2 Secretary may not provide for receipt or processing
3 of applications for enrollment under this title—

4 “(A) by any non-Federal entity which is
5 directly or indirectly involved in the administra-
6 tion of title IV, XVI, or XIX of this Act, or

7 “(B) by any entity which does not meet
8 such standards as the Secretary establishes to
9 assure the confidentiality of information col-
10 lected in the enrollment process.

11 **“SEC. 2203. COVERAGE PERIOD; TERMINATION OF ENROLL-**
12 **MENT.**

13 “(a) BEGINNING OF COVERAGE.—The provisions of
14 section 2152(b) shall apply to the public health plan in
15 the same manner as they apply to qualified health plans.

16 “(b) TERMINATION OF ENROLLMENT DURING TRAN-
17 SITION PERIOD.—

18 “(1) IN GENERAL.—Before January 1, 1997,
19 except as provided in paragraph (3)—

20 “(A) an individual enrolled under this title
21 may terminate enrollment on a non-employment
22 basis by providing written notice to the Sec-
23 retary that the individual—

24 “(i) no longer wishes to be enrolled in
25 the public health plan, or

1 “(ii) is enrolled under a qualified em-
2 ployer health plan or is a medicare bene-
3 ficiary; and

4 “(B) the Secretary may terminate enroll-
5 ment on a non-employment basis of an individ-
6 ual, after providing the individual (or the indi-
7 vidual’s representative) with written notice, for
8 failure to pay premiums required with respect
9 to such enrollment.

10 The termination of enrollment of an individual
11 (other than due to the individual becoming a medi-
12 care beneficiary) shall terminate the enrollment of
13 other family members enrolled with the individual.

14 “(2) EFFECTIVE DATE OF TERMINATION.—A
15 termination of enrollment under paragraph (1)(A)
16 shall take effect at the close of the month following
17 the month in which the notice is filed. A termination
18 of enrollment under paragraph (1)(B) shall take ef-
19 fect on a date (determined under regulations) after
20 the date written notice of such termination has been
21 provided to the enrollee (or the enrollee’s representa-
22 tive). Such regulations shall provide a grace period
23 of at least 1 month after the date of written notice
24 in which overdue premiums may be paid and cov-
25 erage continued.

1 “(3) MINIMUM PERIOD OF ENROLLMENT DUR-
2 ING TRANSITION.—Subject to paragraph (4), before
3 January 1, 1997—

4 “(A) IN GENERAL.—An individual (other
5 than a pregnant woman or newborn) who is en-
6 rolled under this title on a non-employment
7 basis may not terminate enrollment less than
8 12 months after the date of the enrollment.

9 “(B) PREGNANT WOMEN AND
10 NEWBORNS.—In the case of a pregnant woman
11 who is enrolled under this title on a non-em-
12 ployment basis—

13 “(i) the enrollment of the woman may
14 not be terminated earlier than the end of
15 the month in which the 60-day period, be-
16 ginning on the last day of the pregnancy,
17 ends; and

18 “(ii) the newborn child shall be
19 deemed enrolled under this title as of the
20 date of birth, and such enrollment may not
21 be terminated earlier than the end of the
22 month in which the child’s first birthday
23 occurs.

24 “(4) TERMINATION PERMITTED IF COVERED
25 UNDER QUALIFIED EMPLOYER HEALTH PLAN.—The

1 minimum period of enrollment under paragraph (3)
2 shall not apply if, at the time of termination of en-
3 rollment, the individual is immediately covered under
4 a qualified employer health plan which will provide
5 coverage during the minimum period for which en-
6 rollment is otherwise required under such para-
7 graph.

8 “(c) TERMINATION OF ENROLLMENT AFTER TRAN-
9 SITION PERIOD.—For limitations on termination of enroll-
10 ment under this title on or after January 1, 1997, see
11 section 2204(c).

12 **“SEC. 2204. REQUIREMENT OF HEALTH INSURANCE COV-
13 ERAGE.**

14 “(a) REQUIREMENT FOR ALL ELIGIBLE INDIVID-
15 UALS.—

16 “(1) IN GENERAL.—Effective on and after the
17 date specified in subsection (e), each eligible individ-
18 ual (as defined in section 2201(d)) who is not an ex-
19 cepted individual (as defined in paragraph (2)), is
20 deemed to have enrolled under this title on the date
21 before such date or as soon thereafter as the individ-
22 ual is not an excepted individual. If such an individ-
23 ual has not filed an application for enrollment under
24 this title by such date, the Secretary shall provide a

1 means to collect information sufficient to effect such
2 enrollment as soon as possible after such date.

3 “(2) EXCEPTED INDIVIDUALS.—For purposes
4 of paragraph (1), the term ‘excepted individual’
5 means an individual who—

6 “(A) is a medicare beneficiary,

7 “(B) is enrolled under a qualified employer
8 health plan, or

9 “(C) demonstrates (in a manner specified
10 by the Secretary) enrollment under a Federal
11 health plan (as defined in subsection (f)).

12 “(b) AUTOMATIC CONTINUING ENROLLMENT.—For
13 provisions relating to coordination of enrollment among
14 qualified health plans and assuring continuous coverage
15 for required health services (and portability of health in-
16 surance benefits among such plans), see section 2157.

17 “(c) LIMITATION ON TERMINATION OF ENROLL-
18 MENT.—Effective on the date specified in subsection (e)—

19 “(1) EMPLOYMENT-BASED ENROLLMENT.—An
20 individual enrolled under this title on an employment
21 basis may not elect to terminate such enrollment.

22 “(2) NON-EMPLOYMENT BASIS.—An individual
23 enrolled under this title on a non-employment basis
24 may not terminate such enrollment unless—

1 “(A) the individual is no longer eligible to
2 be enrolled under this title because of a change
3 of immigration or residency status, or

4 “(B) the individual demonstrates to the
5 satisfaction of the Secretary that the individual
6 is a medicare beneficiary or is enrolled under a
7 qualified employer health plan.

8 “(d) ENFORCEMENT.—

9 “(1) MONITORING OF INDIVIDUAL TAX RE-
10 TURNS.—The Secretary of the Treasury shall re-
11 quire the filing of such information as may be nec-
12 essary to establish compliance with subsection (a).

13 “(2) RETROACTIVE ENROLLMENT.—If such an
14 individual has not provided evidence of enrollment in
15 a qualified employer health plan or Federal health
16 plan, the Secretary—

17 “(A) shall enroll the individual pursuant to
18 the filing of such return, and

19 “(B) shall require the payment of twice the
20 amounts of premiums that would have been
21 paid if the person had been enrolled on a timely
22 basis, unless the individual has established to
23 the satisfaction of the Secretary good cause for
24 the failure to enroll on a timely basis.

1 “(e) EFFECTIVE DATE OF REQUIREMENT.—The
2 date specified in this subsection is January 1, 1997.

3 “(f) FEDERAL HEALTH PLAN DEFINED.—In this
4 section, the term ‘Federal health plan’ means a health
5 plan of, or contributed to by, the Federal Government on
6 behalf of its employees, retirees, and their family mem-
7 bers, and includes—

8 “(1) the Federal employees health insurance
9 program under chapter 89 of title 5, United States
10 Code,

11 “(2) the program for the provision of medical
12 and dental benefits under chapter 55 of title 10,
13 United States Code, and

14 “(3) the program for the provision of hospital
15 care and medical services by the Department of Vet-
16 erans’ Affairs under chapter 17 of title 38, United
17 States Code.

18 “PART B—HEALTH INSURANCE BENEFITS

19 **“SEC. 2211. REQUIRED HEALTH SERVICES.**

20 “(a) MEDICARE BENEFITS.—

21 “(1) IN GENERAL.—Except as provided in the
22 succeeding provisions of this part and part C, the
23 health insurance benefits provided to an individual
24 enrolled under this title (whether on an employment
25 basis or a non-employment basis) shall consist of en-

1 entitlement to the same benefits as are provided under
2 title XVIII to individuals entitled to benefits under
3 part A, and enrolled under part B, of title XVIII.

4 “(2) REQUIRED HEALTH SERVICES DEFINED.—

5 In this title and title XXI, the term ‘required health
6 services’ means the services provided under this title
7 (including services described in subsections (b) and
8 (c)).

9 “(b) UNLIMITED INPATIENT HOSPITAL SERVICES
10 FOR CHILDREN.—For children, required health benefits
11 also shall include payment for inpatient hospital services
12 without regard to any day limitations under subsections
13 (a)(1) and (b)(1) of section 1812.

14 “(c) PREGNANCY-RELATED SERVICES.—

15 “(1) IN GENERAL.—In the case of a pregnant
16 woman (as defined in section 2283(3)), benefits
17 under this title shall include entitlement to have pay-
18 ment made for the following, subject to the periodic-
19 ity schedule established with respect to the services
20 under paragraph (2) and prior authorization of cer-
21 tain services under paragraph (3):

22 “(A) Prenatal care, including care for all
23 complications of pregnancy.

24 “(B) Inpatient labor and delivery services.

25 “(C) Postnatal care.

1 “(D) Postnatal family planning services.

2 “(2) PERIODICITY SCHEDULE.—The Secretary,
3 in consultation with the American College of Obstet-
4 rics and Gynecology, shall establish a schedule of pe-
5 riodicity which reflects the general, appropriate fre-
6 quency with which services listed in paragraph (1)
7 should be provided to pregnant women without com-
8 plications of pregnancy.

9 “(3) PRIOR AUTHORIZATION REQUIRED FOR
10 CERTAIN SERVICES.—

11 “(A) IN GENERAL.—Except in the case of
12 items and services specified under subpara-
13 graph (B), benefits are not available with re-
14 spect to an item or service under paragraph (1)
15 unless the provision of the item or service has
16 been approved by a utilization and quality con-
17 trol peer review organization before the provi-
18 sion of the item or service.

19 “(B) EXCEPTION FOR ROUTINE OR COM-
20 MON ITEMS AND SERVICES.—Subparagraph (A)
21 shall not apply to items and services which the
22 Secretary has specified on a list as being ei-
23 ther—

24 “(i) related to normal pregnancy, or

1 “(ii) related to a highly prevalent
2 complication of pregnancy,
3 or in the case of emergency services.

4 “(d) PREVENTIVE SERVICES DEFINED.—In this title,
5 the term ‘preventive services’ means the following items
6 and services furnished in accordance with any applicable
7 periodicity schedules:

8 “(1) Pregnancy-related services (described in
9 subsection (c)(1)).

10 “(2) Well-child care (as defined in section
11 1861(ll)(1)).

12 “(3) Screening mammography (as defined in
13 section 1861(jj)).

14 “(4) Screening pap smear (as defined in section
15 1861(nn)).

16 “(5) Colorectal cancer screening services.

17 “(6) Immunization services described in section
18 1862(a)(1)(H).

19 The services referred to in paragraph (5) are screening
20 fecal-occult blood tests and screening flexible
21 sigmoidoscopies provided for the purpose of early detection
22 of colon cancer.

1 “PART C—PAYMENTS FOR BENEFITS; DEDUCTIBLES,
2 COINSURANCE, AND STOP-LOSS PROTECTION FOR
3 REQUIRED HEALTH SERVICES

4 **“SEC. 2221. PAYMENTS FOR BENEFITS.**

5 “(a) USE OF MEDICARE PAYMENT RULES.—

6 “(1) IN GENERAL.—Except as otherwise pro-
7 vided in this title—

8 “(A) payment of benefits under this title
9 with respect to services shall be made, subject
10 to adjustment in payment rates under sub-
11 section (b), in the same amounts and on the
12 same basis as payment may be made with re-
13 spect to such services under title XVIII, and

14 “(B) the provisions of sections 1814, 1815,
15 1833, 1834, 1835, 1842, 1848, 1886, 1887
16 shall apply to payment of benefits (and provi-
17 sion of services and charges thereon) under this
18 title in the same manner as they apply to bene-
19 fits, services, and charges under title XVIII.

20 “(2) IDENTIFICATION OF COMPARABLE PAY-
21 MENT METHODS FOR NEW SERVICES.—In the case
22 of services for which there is not a payment basis es-
23 tablished under title XVIII, the Secretary shall es-
24 tablish payment rules that are similar to the pay-
25 ment rules for similar services under such title.

1 “(3) NO JUDICIAL OR ADMINISTRATION RE-
2 VIEW.—There shall be no administrative or judicial
3 review of the payment rates or rules under this sec-
4 tion (including adjustments made under subsection
5 (b)).

6 “(b) PAYMENT BASED ON APPROVED RATES.—

7 “(1) IN GENERAL.—Payments for services
8 under this title shall be based on rates approved by
9 the Federal Health Care Cost Containment Commis-
10 sion under title III of the Health Insurance Cov-
11 erage and Cost Containment Act of 1993.

12 “(2) PAYMENT FOR OBSTETRICAL SERVICES.—

13 “(A) GLOBAL FEE.—In making payment
14 under this title with respect to the group of ob-
15 stetrical services typical of treatment through-
16 out a course of pregnancy, the Secretary shall
17 establish a global fee schedule with respect to
18 such group of services.

19 “(B) DISINCENTIVE FOR CESAREAN SEC-
20 TIONS.—The fee schedule amount otherwise es-
21 tablished with respect to a cesarean section
22 shall be 95 percent of the fee schedule amount
23 otherwise established.

24 “(c) USE OF TRUST FUND.—In applying the provi-
25 sions described in subsection (a)(1)(B) in carrying out this

1 section, any reference in title XVIII to a trust fund shall
2 be treated as a reference to the Public Health Trust Fund
3 established under section 2233.

4 “(d) WITHHOLDING OF PAYMENTS FOR CERTAIN
5 MEDICARE AND MEDICAID PROVIDERS.—The provisions
6 of section 1885 (relating to withholding of payments for
7 certain medicaid providers) shall apply under this title in
8 the same manner as they apply under title XVIII, except
9 that for this purpose any reference in such section to title
10 XIX shall be deemed to include a reference to title XVIII.

11 **“SEC. 2222. DEDUCTIBLE FOR REQUIRED HEALTH SERV-**
12 **ICES.**

13 “(a) DEDUCTIBLE.—

14 “(1) IN GENERAL.—Except as provided in this
15 section and part E, the amount of expenses for re-
16 quired health services with respect to which an indi-
17 vidual is entitled to have payment made under this
18 title for any year shall first be reduced by a deduct-
19 ible of \$250.

20 “(2) FAMILY LIMIT OF \$500.—In the case of a
21 family, the deductible under paragraph (1) shall not
22 apply in a year after members of the family (who
23 are not medicare beneficiaries) have collectively had
24 expended \$500 towards such deductible.

1 “(3) APPLICATION OF DEDUCTIBLE IN PLACE
 2 OF MEDICARE DEDUCTIBLES.—Under this title, the
 3 deductible established under this subsection shall be
 4 applied instead of applying the deductible for inpa-
 5 tient hospital services under the first sentence of
 6 section 1813(a)(1) and the deductible under section
 7 1833(b).

8 “(4) INDEXING OF DOLLAR AMOUNTS OF DE-
 9 DUCTIBLE.—The dollar amounts specified in para-
 10 graphs (1) and (2) shall each be increased each year
 11 (beginning with second year after the year in which
 12 this title is enacted) by a percentage equal to the
 13 percentage increase in the contribution and benefit
 14 base (determined under section 230) from the year
 15 before the year in which this title is enacted to the
 16 year before the year involved. Any such increase
 17 shall be rounded to the nearest multiple of \$5.

18 “(b) DEDUCTIBLE DOES NOT APPLY TO PREVEN-
 19 TIVE SERVICES.—The deductible established under sub-
 20 section (a) does not apply to preventive services provided
 21 consistent with any applicable periodicity schedules.

22 **“SEC. 2223. COINSURANCE FOR REQUIRED HEALTH SERV-**
 23 **ICES.**

24 “(a) COINSURANCE RATES.—Subject to subsections
 25 (b) and (c) and part E, the coinsurance rates applicable

1 to required health services under title XVIII shall apply
2 in the administration of this title.

3 “(b) NO COINSURANCE FOR PREVENTIVE SERV-
4 ICES.—There shall be no coinsurance under this title in
5 the case of preventive services provided consistent with
6 any applicable periodicity schedules.

7 “(c) NO COINSURANCE FOR INPATIENT HOSPITAL
8 SERVICES FOR CHILDREN.—There shall be no coinsur-
9 ance under this title in the case of inpatient hospital serv-
10 ices furnished to children.

11 **“SEC. 2224. LIMIT ON COST-SHARING FOR REQUIRED**
12 **HEALTH SERVICES.**

13 “(a) LIMITATION.—

14 “(1) IN GENERAL.—Whenever in a calendar
15 year an individual’s or family’s expenses for the de-
16 ductible and coinsurance with respect to required
17 health services covered under this title and furnished
18 during the year equals \$2,500 or \$3,000, respec-
19 tively, payment of benefits under this title for the in-
20 dividual or family for required health services fur-
21 nished during the remainder of the year shall be
22 paid without the application of any coinsurance.

23 “(2) INDEXING OF DOLLAR AMOUNT OF
24 LIMIT.—The dollar amounts specified in paragraph
25 (1) shall be increased each year (beginning with the

1 second year after the year in which this title is en-
2 acted) by a percentage equal to the percentage in-
3 crease in the contribution and benefit base (deter-
4 mined under section 230) from the year before the
5 year in which this title is enacted to the year before
6 the year involved. Any such increase shall be round-
7 ed to the nearest multiple of \$5.

8 “(b) CREDITING FOR EXPENSES INCURRED UNDER
9 QUALIFIED EMPLOYER HEALTH PLANS.—Cost sharing
10 incurred under a qualified employer health plan for re-
11 quired health services shall be credited under this section
12 against the limits contained in subsection (a).

13 **“SEC. 2225. EXCLUSIONS; COORDINATION.**

14 “(a) EXCLUSIONS.—

15 “(1) IN GENERAL.—Except as provided in this
16 section, section 1862 shall apply to expenses in-
17 curred for items and services provided under this
18 title the same manner as such section applies to
19 items and services provided under title XVIII.

20 “(2) PREVENTIVE SERVICES.—In the case of
21 preventive services provided consistent with the ap-
22 plicable periodicity schedule—

23 “(A) such services shall be considered to be
24 reasonable and medically necessary, and

1 “(B) shall not be subject to exclusion
 2 through the operation of paragraph (1), (7), or
 3 (12) of section 1862(a) (as incorporated under
 4 paragraph (1)).

5 “(3) USE OF SAME NATIONAL COVERAGE DECI-
 6 SION REVIEW PROCESS.—The provisions of section
 7 1869(b)(3) shall apply under this title in the same
 8 manner as they apply under title XVIII. Any deter-
 9 mination under such title that, under paragraph (1),
 10 would apply under this title shall not be subject to
 11 review under this paragraph.

12 “(b) RELATIONSHIP TO MEDICARE IN CASE OF EM-
 13 PLOYMENT-BASED ENROLLMENT.—In the case of enroll-
 14 ment of a medicare beneficiary on an employment basis
 15 under this title, in applying section 1862(b) (pursuant to
 16 subsection (a)(2) of this section), the public health plan
 17 shall be treated as a large group health plan (described
 18 in section 1862(b)).

19 **“SEC. 2226. APPLICATION OF PARTICULAR QUALIFIED**
 20 **HEALTH PLAN REQUIREMENTS.**

21 “Section 2152 (relating treatment of family members
 22 as a unit; coverage period; and health plan cards) and sec-
 23 tion 2157 (relating to coordination and portability of
 24 health coverage under qualified health plans) shall apply

1 to the public health plan in the same manner as they apply
2 to a qualified health plan.

3 “PART D—PREMIUMS, PUBLIC HEALTH TRUST FUND

4 “**SEC. 2231. PREMIUMS.**

5 “(a) AMOUNT OF PREMIUMS.—

6 “(1) IN GENERAL.—Except as provided in this
7 section (and section 2234 with respect to
8 nonenrolling employer premiums), the premium to
9 be charged for enrollment under this title of any in-
10 dividual in a beneficiary class (as defined in sub-
11 section (d)) in any community (as defined in sub-
12 section (e)) is the actuarial rate established under
13 paragraph (2) with respect to such class and com-
14 munity.

15 “(2) CREDIT FOR EMPLOYMENT TAXES PAID
16 FOR PART-TIME AND SEASONAL OR TEMPORARY EM-
17 PLOYEES.—

18 “(A) IN GENERAL.—Subject to subpara-
19 graph (C), in the case of an individual who is
20 a covered employee (as defined in subparagraph
21 (B)), the premium to be charged for enrollment
22 under this title on a non-employment basis is—

23 “(i) the actuarial rate otherwise appli-
24 cable under paragraph (1), less the amount
25 of the taxes paid by the individual and all

1 employers with respect to the employee
2 (and family members of the employee)
3 under section 3151(a) of the Internal Rev-
4 enue Code of 1986, or

5 “(ii) 20 percent of such actuarial rate,
6 whichever is greater.

7 “(B) COVERED EMPLOYEE DEFINED.—In
8 subparagraph (A), the term ‘covered employee’
9 means an individual—

10 “(i) who is employed by one or more
11 employers as a part-time employee or as a
12 seasonal or temporary employee, and

13 “(ii) none of whose employers is en-
14 rolling part-time employees or seasonal or
15 temporary employees, respectively, under a
16 qualified employer health plan, but all of
17 which are required to pay a tax with re-
18 spect to such employees under section
19 3151(a)(1) of the Internal Revenue Code
20 of 1986,

21 and includes the family members of such an
22 employee.

23 “(C) LIMIT ON PREMIUM WHERE PREMIUM
24 SUBSIDY.—In no case shall the premium under
25 subparagraph (A) exceed—

1 “(i) the beneficiary actuarial rate oth-
2 erwise applicable under paragraph (1), re-
3 duced by

4 “(ii) the amount of any premium sub-
5 sidy under part E.

6 “(b) DETERMINATION OF ACTUARIAL RATES.—

7 “(1) IN GENERAL.—In September of each year,
8 beginning with 1993, the Secretary shall determine
9 and publish the actuarial rate for each beneficiary
10 class (as specified in subsection (d)) for each com-
11 munity (designated under subsection (e)) for health
12 insurance benefits in the following year.

13 “(2) BASIS FOR ACTUARIAL RATES.—Each such
14 actuarial rate shall be established in a manner so
15 that if all eligible individuals in the class were en-
16 rolled under this title for the benefit package in the
17 community, the aggregate of the rates would be
18 equal to the total expenditures (including adminis-
19 trative expenses) with respect to that class and com-
20 munity under this title in that following year. Each
21 such actuarial rate shall be uniform within each ben-
22 eficiary class and community, and shall not vary
23 among such individuals by age, sex, health, or other
24 risk characteristics.

1 “(3) PUBLIC STATEMENT.—Whenever the Sec-
2 retary publishes actuarial rates under this sub-
3 section, the Secretary shall, at the time of such pub-
4 lication, include a public statement setting forth the
5 actuarial assumptions and bases employed in arriv-
6 ing at the amount of the actuarial rates.

7 “(c) NO JUDICIAL OR ADMINISTRATION REVIEW.—
8 There shall be no administrative or judicial review of the
9 actuarial rates determined under this section.

10 “(d) BENEFICIARY CLASSES.—For purposes of this
11 section, the beneficiary classes are as follows:

12 “(1) 1 adult.

13 “(2) A married couple without children.

14 “(3) A married couple with 1 or more children,
15 or 1 adult with 1 or more children.

16 “(e) COMMUNITY.—For purposes of this section, the
17 term ‘community’ means a geographic area designated by
18 the Secretary as—

19 “(1) encompassing one or more adjacent metro-
20 politan statistical areas, or

21 “(2) the remaining area within each State (that
22 is not designated within any community under para-
23 graph (1));

24 except that the Secretary may designate an entire State
25 as a community if such a designation would better carry

1 out the purposes of this title and title XXIII. The Sec-
2 retary from time to time may change the boundaries of
3 communities designated under paragraph (1) or (2) for
4 such purposes. There shall be no administrative or judicial
5 review of the designation of communities under this sub-
6 section.

7 **“SEC. 2232. COLLECTION OF PREMIUMS.**

8 “(a) INDIVIDUAL ENROLLMENT.—

9 “(1) IN GENERAL.—In the case of individuals
10 enrolled on a non-employment basis under this title,
11 the Secretary shall provide for the payment of pre-
12 miums on a monthly or quarterly basis. To the max-
13 imum extent feasible, the Secretary shall arrange for
14 payment of such premiums through automatic with-
15 holding from income sources or accounts with finan-
16 cial institutions. In the case of a part-time employee
17 or seasonal or temporary worker, the amount of the
18 premiums owed under this section shall be reduced
19 by the amount of excise taxes paid under section
20 3151(a) of the Internal Revenue Code of 1986 with
21 respect to such employment.

22 “(2) COLLECTION OF UNPAID PREMIUMS.—

23 “(A) TRANSMISSION OF INFORMATION TO
24 SECRETARY OF THE TREASURY.—In the case of
25 premium amounts owing and unpaid under this

1 subsection, the Secretary shall inform the Sec-
2 retary of the Treasury of individuals or individ-
3 uals owing such amounts and the amounts
4 owed.

5 “(B) COLLECTION.—The Secretary of the
6 Treasury shall assess and collect the amounts
7 referred to in subparagraph (A) in the same
8 manner as taxes imposed by subtitle C of the
9 Internal Revenue Code of 1986.

10 “(b) NONENROLLING EMPLOYER PREMIUMS.—

11 “(1) EMPLOYER PREMIUMS.—In the case of an
12 individual enrolled under this title on an employment
13 basis, the employer shall provide for payment of pre-
14 miums on a monthly or quarterly basis.

15 “(2) NONENROLLING EMPLOYER PREMIUMS.—
16 In the case of nonenrolling employer premiums owed
17 under section 2234, the Secretary shall require pay-
18 ment of premiums on a monthly or quarterly basis.

19 “(3) COLLECTION OF UNPAID PREMIUMS.—

20 “(A) TRANSMISSION OF INFORMATION TO
21 SECRETARY OF THE TREASURY.—In the case of
22 premium amounts owing and unpaid under this
23 subsection, the Secretary shall inform the Sec-
24 retary of the Treasury of the employers owing
25 such amounts and the amounts owed.

1 “(B) COLLECTION.—The Secretary of the
2 Treasury shall assess and collect the amounts
3 referred to in subparagraph (A) in the same
4 manner as taxes imposed by subtitle C of the
5 Internal Revenue Code of 1986.

6 “(c) DEPOSIT.—Premiums collected under this sec-
7 tion shall be deposited to the credit of the Public Health
8 Trust Fund (established under section 2233).

9 **“SEC. 2233. PUBLIC HEALTH TRUST FUND.**

10 “(a) ESTABLISHMENT.—

11 “(1) IN GENERAL.—There is hereby created on
12 the books of the Treasury of the United States a
13 trust fund to be known as the ‘Public Health Trust
14 Fund’ (in this section referred to as the ‘Trust
15 Fund’). The Trust Fund shall consist of such gifts
16 and bequests as may be made as provided in para-
17 graph (3) and such amounts as may be deposited in,
18 or appropriated to, such Trust Fund as provided in
19 this part.

20 “(2) DEPOSIT OF TAXES.—There are hereby
21 appropriated to the Trust Fund amounts equivalent
22 to 100 percent of the taxes imposed by—

23 “(A) part VIII of subchapter A of chapter
24 1 of the Internal Revenue Code of 1986, and

1 “(B) sections 3151, 5000A, and 5000B of
2 such Code.

3 The amounts appropriated by the preceding sentence
4 shall be transferred from time to time from the gen-
5 eral fund in the Treasury to the Trust Fund, such
6 amounts to be determined on the basis of estimates
7 by the Secretary of the Treasury of the taxes, paid
8 to or deposited into the Treasury; and proper adjust-
9 ments shall be made in amounts subsequently trans-
10 ferred to the extent prior estimates were in excess
11 of or were less than the taxes specified in such
12 sentence.

13 “(3) AUTHORIZATION TO ACCEPT GIFTS.—The
14 Managing Trustee of the Trust Fund is authorized
15 to accept on behalf of the United States money gifts
16 and bequests made unconditionally to the Trust
17 Fund, for the benefit of the Trust Fund, or any ac-
18 tivity financed through the Trust Fund.

19 “(b) INCORPORATION OF PROVISIONS.—

20 “(1) IN GENERAL.—Subject to paragraph (2),
21 the provisions of subsections (b) through (j) of sec-
22 tion 1817 shall apply to the Trust Fund in the same
23 manner as they apply to the Federal Hospital Insur-
24 ance Trust Fund.

1 “(2) EXCEPTIONS.—In applying paragraph
2 (1)—

3 “(A) the Board of Trustees and Managing
4 Trustee of the Trust Fund shall be composed of
5 the members of the Board of Trustees and the
6 Managing Trustee, respectively, of the Federal
7 Hospital Insurance Trust Fund; and

8 “(B) any reference in section 1817 to the
9 Federal Hospital Insurance Trust Fund, to title
10 XVIII (or part A thereof), or (in subsection
11 (f)(1)) to section 3102(b) of the Internal Reve-
12 nue Code of 1986 is deemed a reference to the
13 Trust Fund under this section, this title, and to
14 section 3151(a)(2) of such Code, respectively.

15 “(3) TRANSFERS TO HOSPITAL INSURANCE
16 TRUST FUND.—There shall be transferred periodi-
17 cally (but not less often than monthly) from the
18 Trust Fund to the Federal Hospital Insurance Trust
19 Fund, amounts equivalent to the premium, deduct-
20 ible, and coinsurance subsidies provided under part
21 E of this title with respect to premiums, deductibles,
22 and coinsurance under part A of title XVIII.

23 “(4) TRANSFERS TO SMI TRUST FUND.—There
24 shall be transferred periodically (but not less often
25 than monthly) from the Trust Fund to the Federal

1 Supplementary Medical Insurance Trust Fund,
2 amounts equivalent to the sum of—

3 “(A) to the premium, deductible, and coin-
4 surance subsidies provided under part E of this
5 title with respect to premiums, deductibles, and
6 coinsurance under part B of title XVIII;

7 “(B) the net additional expenditures under
8 part B of such title resulting from the amend-
9 ments made by sections 501 through 504 and
10 507 of the Health Insurance Coverage and Cost
11 Containment Act of 1993.

12 **“SEC. 2234. TRANSFER PAYMENTS IN THE CASE OF MUL-**
13 **TIPLE EMPLOYERS.**

14 “(a) TREATMENT OF MULTIPLE EMPLOYMENT
15 WHERE EMPLOYEE COVERED UNDER A QUALIFIED EM-
16 PLOYER HEALTH PLAN.—

17 “(1) IN GENERAL.—In the case of a multiple-
18 employed individual (as defined in subsection (d)(1))
19 who is covered under a qualified employer health
20 plan of an employer—

21 “(A) each nonenrolling employer (as de-
22 fined in subsection (d)(2)) that offers coverage
23 under a qualified employer health plan shall pay
24 to the Public Insurance Trust Fund the

1 nonenrolling employer premium specified in
2 subsection (b);

3 “(B) the enrolling employer is entitled to
4 receive from such Trust Fund the enrolling em-
5 ployer subsidy specified in subsection (c); and

6 “(C) there will be no tax imposed on the
7 wages of the individual under section
8 3151(a)(2) of the Internal Revenue Code of
9 1986 with respect to wages paid during the pe-
10 riod of such coverage.

11 “(2) APPLICATION ON A MONTHLY BASIS.—The
12 premiums and subsidies provided under this sub-
13 section shall be paid with respect to a monthly pe-
14 riod of coverage.

15 “(b) AMOUNT OF NONENROLLING EMPLOYER PRE-
16 MIUM.—

17 “(1) IN GENERAL.—The amount of the
18 nonenrolling employer premium described in this
19 subsection is the applicable percent of the actuarial
20 rate (specified in section 2226(b)) for the beneficiary
21 class in the community in which the employee is
22 enrolled.

23 “(2) APPLICABLE PERCENT DEFINED.—For
24 purposes of paragraph (1), the term ‘applicable per-
25 cent’ means, with respect to an employee who is—

1 “(A) a full-time employee of the employer,
2 40 percent, or

3 “(B) a part-time employee of the employer,
4 20 percent.

5 “(c) AMOUNT OF ENROLLING EMPLOYER SUB-
6 SIDY.—

7 “(1) IN GENERAL.—The amount of the enroll-
8 ing employer subsidy described in this subsection is
9 the applicable percent of the actuarial rate (specified
10 in section 2226(b)) for the beneficiary class in the
11 community in which the employee is enrolled.

12 “(2) APPLICABLE PERCENT DEFINED.—For
13 purposes of paragraph (1), the term ‘applicable per-
14 cent’ means, with respect to a multiple-employee
15 who (or whose spouse) is—

16 “(A) a full-time employee of a nonenrolling
17 employer, 40 percent, or

18 “(B) not a full-time employee of a
19 nonenrolling employer, but is a part-time em-
20 ployee of a nonenrolling employer, 20 percent.

21 In no case shall the applicable percent with respect
22 to a multiple-employed employee (including the em-
23 ployee’s spouse) exceed 40 percent.

24 “(d) DEFINITIONS.—In this section:

1 “(1) MULTIPLE-EMPLOYED INDIVIDUAL.—The
2 term ‘multiple-employed individual’ means an indi-
3 vidual who in a month is an employee (whether part-
4 time or full-time) and—

5 “(A) who is also employed (whether part-
6 time or full-time) by 1 or more other employer,
7 or

8 “(B) whose spouse or parent is also an em-
9 ployee (whether part-time or full-time) of 1 or
10 more employers.

11 “(2) NONENROLLING EMPLOYER.—The term
12 ‘nonenrolling employer’ means, with respect to a
13 multiple-employed individual who is enrolled under a
14 qualified employer health plan of an employer, any
15 employer of such individual other than such em-
16 ployer.

17 **“SEC. 2235. USE OF UNIFORM CLAIMS FORMS; UNIFORM IN-**
18 **FORMATION REPORTING.**

19 “The Secretary shall provide for—

20 “(1) submission of claims under this title (and
21 title XVIII) in accordance with section 323 of the
22 Health Insurance Coverage and Cost Containment
23 Act of 1993, and

24 “(2) reporting to the Commission of informa-
25 tion on required health services provided under this

1 title (or title XVIII) pursuant to standards promul-
2 gated under section 324 of such Act.

3 “PART E—ASSISTANCE FOR LOW-INCOME INDIVIDUALS
4 **“SEC. 2241. ASSISTANCE FOR INDIVIDUALS WITH INCOME**
5 **BELOW THE POVERTY LINE ENROLLED ON A**
6 **NON-EMPLOYMENT BASIS.**

7 “In the case of an individual—

8 “(1) who is enrolled under this title on a non-
9 employment basis,

10 “(2) who is not a medicare beneficiary, and

11 “(3) whose family adjusted total income (as de-
12 fined in section 2247) does not exceed 100 percent
13 of the official poverty line (as defined in section
14 2283(2)),

15 the low-income assistance under this part shall consist of
16 waiver of the premiums imposed under section 2231(a)
17 and of any deductibles or coinsurance under this title for
18 the individual and the individual’s family.

19 **“SEC. 2242. ASSISTANCE FOR INDIVIDUALS WITH INCOME**
20 **BELOW TWICE THE POVERTY LINE EN-**
21 **ROLLED ON A NON-EMPLOYMENT BASIS.**

22 “(a) NON-MEDICARE POPULATION.—In the case of
23 an individual who is not a medicare beneficiary, who is
24 enrolled under this title on a non-employment basis, and
25 whose family adjusted total income exceeds 100 percent

1 but is less than 200 percent, of the official poverty line,
2 the low-income assistance under this part shall consist of
3 the following:

4 “(1) PREMIUMS.—The premium amount under
5 section 2231(a) shall be reduced by the subsidy per-
6 centage (as defined in subsection (b)) of the pre-
7 mium amount otherwise applied. Any reduction in
8 premium under this paragraph shall be rounded to
9 the nearest multiple of \$5.

10 “(2) DEDUCTIBLE.—The deductibles under sec-
11 tion 2222 shall be reduced by the subsidy percentage
12 of the deductibles otherwise applied. Any reduction
13 in a deductible under this paragraph shall be round-
14 ed to the nearest multiple of \$10.

15 “(3) COINSURANCE.—The percentage coinsur-
16 ance applied under section 2223 shall be reduced by
17 the subsidy percentage multiplied by the percentage
18 coinsurance otherwise applied.

19 “(b) SUBSIDY PERCENTAGE DEFINED.—

20 “(1) IN GENERAL.—In this section and section
21 2243, the term ‘subsidy percentage’ means the num-
22 ber of percentage points by which the family’s ad-
23 justed total income (expressed as a percent of the
24 applicable official poverty line) is less than 200 per-
25 cent.

1 “(2) ROUNDING FOR COINSURANCE.—For pur-
 2 poses of subsection (a)(3), the subsidy percentage
 3 (as applied to the coinsurance percentage) shall be
 4 rounded to the nearest multiple of 5 percent.

5 **“SEC. 2243. ASSISTANCE FOR INDIVIDUALS COVERED**
 6 **UNDER QUALIFIED EMPLOYER HEALTH**
 7 **PLANS.**

8 “(a) IN GENERAL.—In the case of an eligible individ-
 9 ual who is enrolled under a qualified employer health plan
 10 or is enrolled under this title on an employment basis, low-
 11 income assistance under this part shall consist of—

12 “(1) payment (in a manner specified by the
 13 Secretary) of the amount of the premium subsidy
 14 under subsection (b) to the individual or another
 15 family member, or, in the case described in sub-
 16 section (b)(4), the employer, and

17 “(2) payment to the plan of the amount of the
 18 deductible and coinsurance subsidy under subsection
 19 (c).

20 Such subsidies shall apply to premiums, deductibles, and
 21 coinsurance for the individual and family member covered
 22 on an employment basis under the plan or under this title.

23 “(b) PREMIUM SUBSIDY.—In the case of an eligible
 24 individual who is enrolled under a qualified employer
 25 health plan—

1 “(1) TREATMENT UNDER QUALIFIED EM-
2 PLOYER HEALTH PLAN.—

3 “(A) AMOUNT.—The amount of the pre-
4 mium subsidy under this subsection is the sub-
5 sidy percentage (as defined in section 2242(c))
6 of the employee share of the premium. Any pre-
7 mium subsidy under this paragraph which is
8 not a multiple of \$5 shall be rounded to the
9 nearest multiple of \$5.

10 “(B) USE OF LEAST EXPENSIVE QUALI-
11 FIED PLAN.—In applying subparagraph (A),
12 the amount of the premium subsidy shall be
13 based on the qualified employer health plan
14 available to the employee with the smallest pre-
15 mium payment required of the employee (for
16 the type of individual or family enrollment with
17 which the employee is enrolled).

18 “(C) FREQUENCY OF PAYMENT.—Except
19 as provided in subparagraph (D), the premium
20 subsidy under this subsection shall be paid not
21 less frequently than quarterly or, if the amount
22 of the premium subsidy on a monthly basis ex-
23 ceeds \$20, monthly.

1 “(D) OPTIONAL, DIRECT COORDINATION
2 WITH EMPLOYERS.—In the case of an em-
3 ployee—

4 “(i) who is enrolled under a covered
5 employer health plan,

6 “(ii) who is entitled to assistance
7 under this part,

8 “(iii) whose employer agrees to enter
9 into an arrangement with the Secretary
10 under this subparagraph, and

11 “(iv) who assigns (in the manner
12 specified by the Secretary) rights to pre-
13 mium subsidies under this paragraph to
14 the employer,

15 the Secretary shall enter into an arrangement
16 with the employer under which (I) the employer
17 agrees to reduce premiums otherwise imposed
18 with respect to the individual by the amount of
19 the subsidy, and (II) the Secretary agrees to
20 make payment (not less often than monthly) to
21 the employer of the amount of such premium
22 subsidy.

23 “(2) TREATMENT UNDER PUBLIC HEALTH
24 PLAN.—In the case of an eligible individual who is
25 enrolled on an employment basis under this title—

1 “(A) AMOUNT.—The amount of the pre-
2 mium subsidy under this subsection is the sub-
3 sidy percentage (as defined in section 2242(c))
4 of the taxes paid under section 3151(a)(2) of
5 the Internal Revenue Code of 1986.

6 “(B) FREQUENCY OF PAYMENT.—The pre-
7 mium subsidy under this subsection shall be
8 paid not less frequently than quarterly or, if the
9 amount of the premium subsidy on a monthly
10 basis exceeds \$20, monthly.

11 “(c) DEDUCTIBLE AND COINSURANCE SUBSIDY.—

12 “(1) DEDUCTIBLE SUBSIDY AMOUNT.—The
13 amount of the deductible subsidy under this sub-
14 section is the subsidy percentage of the deductible
15 otherwise applied. Any deductible subsidy under this
16 paragraph that is not a multiple of \$10 shall be
17 rounded to the nearest multiple of \$10.

18 “(2) COINSURANCE SUBSIDY AMOUNT.—The
19 amount of the coinsurance subsidy under this sub-
20 section is the product of the subsidy percentage, the
21 percentage coinsurance otherwise applied, and the
22 payment amount permitted for required health serv-
23 ices.

24 “(3) DIRECT COORDINATION BY QUALIFIED EM-
25 PLOYER HEALTH PLAN REQUIRED.—In the case of

1 an individual enrolled under a qualified employer
2 health plan, the plan shall provide for—

3 “(A) acceptance of information, electroni-
4 cally, from the Secretary on the amount of the
5 deductible and coinsurance subsidy for individ-
6 uals (and family members),

7 “(B) a reduction in the deductibles and co-
8 insurance otherwise imposed to reflect the de-
9 ductible and coinsurance subsidies to which the
10 individual and family members are entitled,

11 “(C) reasonably prompt payment of bills
12 for which such charges have been made, and

13 “(D) transmission of such information as
14 is necessary to indicate the amount of subsidy
15 provided under the plan for specified individ-
16 uals.

17 In return, the Secretary shall provide for payment,
18 not less often than monthly, to the plan of the
19 amount of payments made by such a plan for de-
20 ductible and coinsurance subsidies under this sub-
21 section.

22 **“SEC. 2244. APPLICATIONS FOR ASSISTANCE.**

23 “(a) IN GENERAL.—Subject to section 2245, any in-
24 dividual who seeks assistance under this part (with respect
25 to himself or herself or a family member) shall submit a

1 written application, by person or mail, to the Secretary.
2 The application may be submitted with an application to
3 enroll under this title or separately.

4 “(b) BASIS FOR DETERMINATION.—Subject to sec-
5 tion 2245 and reconciliation under such section, eligibility
6 for assistance under this part shall be based on 4 times
7 the family adjusted total income (as defined in section
8 2247) during the 3 months preceding the month in which
9 the application is filed.

10 “(c) FORM AND CONTENTS.—An application for as-
11 sistance under this part shall be in a form and manner
12 specified by the Secretary and shall require—

13 “(1) the provision of information necessary to
14 make the determinations described in subsection (b),

15 “(2) the provision of information respecting any
16 covered employer health plan in which the individual
17 is enrolled, and

18 “(3) the individual (if enrolled under such a
19 plan) to assign rights for deductible subsidies under
20 this part to such plan.

21 Such form also shall include an option to execute, as part
22 of completing the form and in order to meet the condition
23 described in section 2243(b)(4)(D), an assignment of an
24 individual’s right for premium subsidies under this part
25 to an employer.

1 “(d) FREQUENCY OF APPLICATIONS.—

2 “(1) IN GENERAL.—An application for assist-
3 ance under this part may be filed at any time during
4 the year and may be resubmitted (but, except as
5 provided in paragraph (3), not more frequently than
6 once every 3 months) based upon a change of in-
7 come or family composition.

8 “(2) NEED TO REAPPLY.—In the case of an in-
9 dividual who—

10 “(A) is entitled to assistance under this
11 section in September of a year, and

12 “(B) wishes to remain eligible for benefits
13 for months beginning with January of the fol-
14 lowing year,

15 the individual (or a family member) must file with
16 the Secretary in October of that preceding year a
17 new application for assistance. If an individual fails
18 to file a new application under this paragraph, an
19 application for such assistance with respect to any
20 family member may not be filed during November or
21 December of that preceding year.

22 “(3) CORRECTION OF INCOME.—Nothing in
23 paragraph (1) shall be construed as preventing an
24 individual or family from, at any time, submitting an
25 application to reduce the amount of assistance under

1 this part based upon an increase in income from
2 that stated in the previous application.

3 “(e) TIMING OF ASSISTANCE.—

4 “(1) IN GENERAL.—If an application for assist-
5 ance under this part is filed—

6 “(A) on or before the 15th day of a month,
7 assistance under this part shall be available for
8 premiums for months after such month and,
9 with respect to the deductible, for expenses in-
10 curred after such month; or

11 “(B) after the 15th day of a month, assist-
12 ance under this part shall be available for pre-
13 miums for months after the month following
14 such month and, with respect to the deductible,
15 for expenses incurred after such following
16 month.

17 “(2) WELFARE RECIPIENTS.—In the case of an
18 individual or family with respect to whom an appli-
19 cation for assistance is not required because of sec-
20 tion 2246, in applying paragraph (1), the date of ap-
21 proval of aid or benefits described in such section
22 shall be considered the date of filing of an applica-
23 tion for assistance under this part.

24 “(f) VERIFICATION.—The Secretary shall provide for
25 verification, on a sample basis or other basis, of the infor-

1 mation supplied in applications under this part. This ver-
2 ification shall be separate from the reconciliation provided
3 under section 2245.

4 “(g) HELP IN COMPLETING APPLICATIONS.—The
5 Secretary shall provide, from funds appropriated to carry
6 out this title, for grants to public or private nonprofit enti-
7 ties that will make available assistance to individuals and
8 families in filing applications for assistance under this
9 part. The Secretary shall make grants in a manner that
10 provides such assistance at a variety of sites (such as low-
11 income housing projects and shelters for homeless individ-
12 uals) that are readily accessible to individuals and families
13 eligible for assistance under this part.

14 “(h) PENALTIES FOR INACCURATE INFORMATION.—

15 “(1) INTEREST FOR UNDERSTATEMENTS.—

16 Each individual who knowingly understates income
17 reported in an application for assistance under this
18 part or otherwise makes a material misrepresenta-
19 tion of information in such an application shall be
20 liable to the Federal Government for excess pay-
21 ments made based on such understatement or mis-
22 representation, and for interest on such excess pay-
23 ments at a rate specified by the Secretary.

24 “(2) PENALTIES FOR MISREPRESENTATION.—

25 Each individual who knowingly misrepresents mate-

1 rial information in an application for assistance
2 under this part shall be liable to the Federal Govern-
3 ment for \$1,000 or, if greater, three times the ex-
4 cess payments made based on such misrepresenta-
5 tion.

6 “(i) FILING OF APPLICATION DEFINED.—Except as
7 provided in subsection (e)(2), for purposes of this part,
8 an application under this part is considered to be ‘filed’
9 on the date on which the complete application, including
10 all documentation required to act on the application, has
11 been filed with the Secretary.

12 **“SEC. 2245. RECONCILIATION OF PREMIUM ASSISTANCE**
13 **THROUGH USE OF INCOME STATEMENTS.**

14 “(a) REQUIREMENT FOR FILING OF INCOME STATE-
15 MENT.—Subject to section 2246, in the case of a family
16 which is receiving low-income assistance under this part
17 for any month in a year, a member of the family shall
18 file with the Secretary, by not later than April 15 of the
19 following year, a statement that verifies the family’s total
20 adjusted family income for the taxable year ending during
21 the previous year. Such a statement shall provide informa-
22 tion necessary to determine the family adjusted total in-
23 come during the year and the number of family members
24 in the family as of the last day of the year.

1 “(b) RECONCILIATION OF PREMIUM ASSISTANCE
2 BASED ON ACTUAL INCOME.—Based on and using the in-
3 come reported in the statement filed under subsection (a)
4 with respect to a family or individual, subject to section
5 2246, the Secretary shall compute the amount of assist-
6 ance that should have been provided under this part with
7 respect to premiums for the family in the year involved.
8 If the amount of such assistance computed is—

9 “(1) greater than the amount of premium as-
10 sistance provided, the Secretary shall provide for
11 payment (directly or through a credit against future
12 premiums owed) to the family or individual involved
13 of an amount equal to the amount of the deficit, or
14 “(2) less than the amount of assistance pro-
15 vided, the Secretary shall require the family or indi-
16 vidual to pay (directly or through an increase in fu-
17 ture premiums owed) to the Secretary (to the credit
18 of the program under this title) an amount equal to
19 the amount of the excess payment.

20 “(c) DISQUALIFICATION FOR FAILURE TO FILE.—
21 Subject to section 2246, in the case of any family that
22 is required to file an information statement under sub-
23 section (a) in a year and that fails to file such a statement
24 by the deadline specified in such subsection, no member
25 of the family shall be eligible for assistance under this part

1 after May 1 of such year. The Secretary shall waive the
2 application of this subsection if the family establishes, to
3 the satisfaction of the Secretary, good cause for the failure
4 to file the statement on a timely basis.

5 “(d) PENALTIES FOR FALSE INFORMATION.—Any
6 individual that provides false information in a statement
7 under subsection (a) is subject to a criminal penalty to
8 the same extent as a criminal penalty may be imposed
9 under section 1128B(a) with respect to a person described
10 in clause (ii) of such section.

11 “(e) NOTICE OF REQUIREMENT.—The Secretary
12 shall provide for written notice, in March of each year,
13 of the requirement of subsection (a) to each family which
14 received assistance under this part in any month during
15 the preceding year and to which such requirement applies.

16 “(f) TRANSMITTAL OF INFORMATION.—The Sec-
17 retary of the Treasury shall transmit annually to the Sec-
18 retary such information relating to the adjusted total in-
19 come of individuals for the taxable year ending in the pre-
20 vious year as may be necessary to verify the reconciliation
21 of assistance under this section.

22 “(g) CONSTRUCTION.—Nothing in this section shall
23 be construed as authorizing reconciliation of assistance
24 provided with respect to deductibles and coinsurance.

1 **“SEC. 2246. TREATMENT OF CERTAIN CASH ASSISTANCE**
2 **RECIPIENTS.**

3 “In the case of a family that has been determined
4 to be eligible for aid under part A or E of title IV or an
5 individual who has been determined to be eligible for sup-
6 plemental security income benefits under title XVI—

7 “(1) the family or individual is deemed, without
8 the need to file an application for assistance under
9 section 2244, to have adjusted total income below
10 100 percent of the official poverty line applicable to
11 a family of the size involved,

12 “(2) the family or individual need not file a
13 statement under section 2245(a), and

14 “(3) the assistance received by the family is not
15 subject to reconciliation under section 2245(b).

16 **“SEC. 2247. COMPUTATION OF FAMILY ADJUSTED TOTAL**
17 **INCOME.**

18 “In this part:

19 “(1) ADJUSTED TOTAL INCOME.—The term
20 ‘adjusted total income’ means—

21 “(A) adjusted gross income (as defined in
22 section 62(a) of the Internal Revenue Code of
23 1986), determined without the application of
24 paragraphs (6) and (7) of such section and
25 without the application of section 162(l) of such
26 Code, plus

1 “(B) the amount of social security benefits
 2 (described in section 86(d) of such Code) which
 3 is not includable in gross income under section
 4 86 of such Code.

5 “(2) FAMILY ADJUSTED TOTAL INCOME.—The
 6 term ‘family adjusted total income’ means, with re-
 7 spect to an individual, the sum of the adjusted total
 8 income for the individual and all the other family
 9 members.

10 “(3) FAMILY SIZE.—The family size to be ap-
 11 plied under this part, with respect to family adjusted
 12 total income, is the number of individuals included
 13 in the family for purposes of coverage of health in-
 14 surance benefits under this title or under a qualified
 15 employer health plan (as the case may be).

16 “PART F—ADMINISTRATIVE PROVISIONS

17 **“SEC. 2261. AGREEMENTS WITH HOSPITALS; PARTICIPAT-**
 18 **ING PHYSICIANS; TREATMENT OF INDIAN**
 19 **HEALTH SERVICE FACILITIES.**

20 “(a) REQUIREMENT.—

21 “(1) IN GENERAL.—Any hospital shall be quali-
 22 fied to participate under this title and shall be eligi-
 23 ble for payments under this title if—

24 “(A) it has in effect a participation agree-
 25 ment under section 1866(a)(1), and

1 “(B) it files with the Secretary a participa-
2 tion agreement meeting the requirements of
3 subsection (b).

4 “(b) ELEMENTS OF AGREEMENT.—

5 “(1) IN GENERAL.—Except as provided in this
6 subsection, a participation agreement under this
7 subsection shall provide terms, specified by the Sec-
8 retary, that are the same terms as those required of
9 hospital participation agreements under section
10 1866(a)(1).

11 “(2) MODIFIED COPAYMENTS.—Instead of the
12 limitation on charges specified under paragraphs
13 (1)(A) and (2) of section 1866(a), the agreement
14 shall not permit the hospital to charge more than
15 the applicable deductible and coinsurance permitted
16 under this title.

17 “(3) ACCEPTANCE OF PAYMENT LIMITS.—Each
18 agreement shall require the hospital not to impose
19 charges that exceed the payment rates approved
20 under title III of the Health Insurance Coverage and
21 Cost Containment Act of 1993. The previous sen-
22 tence shall not be construed as prohibiting a quali-
23 fied employer health plan from negotiating or other-
24 wise providing payment rates that are less than such
25 reference rates.

1 “(c) PHYSICIAN PARTICIPATION AGREEMENTS.—

2 “(1) IN GENERAL.—Except as provided in this
3 subsection, the Secretary shall provide for participat-
4 ing physician agreements under this title in the
5 same manner as such agreements are provided for
6 under title part B of title XVIII pursuant to section
7 1842(h).

8 “(2) LIMITATION ON CHARGES TO OTHER ENTI-
9 TIES.—A participating physician agreement under
10 this subsection shall provide that the physician
11 agrees not to impose charges with respect to re-
12 quired health services that exceed the payment rates
13 approved with respect to such services under title III
14 of the Health Insurance Coverage and Cost Contain-
15 ment Act of 1993. The previous sentence shall not
16 be construed as prohibiting a qualified employer
17 health plan from negotiating or otherwise providing
18 payment rates that are less than such reference
19 rates.

20 “(d) INDIAN HEALTH SERVICE FACILITIES.—The
21 provisions of section 1880 (relating to Indian health serv-
22 ice facilities) shall apply to this title in the same manner
23 as they apply under title XVIII.

1 **“SEC. 2262. HEALTH MAINTENANCE ORGANIZATIONS.**

2 “(a) IN GENERAL.—Except as provided in this sec-
3 tion, section 1876 shall apply to individuals entitled to
4 benefits under this title in the same manner as such sec-
5 tion applies to individuals entitled to benefits under part
6 A, and enrolled under part B, of title XVIII.

7 “(b) APPLICATION.—In applying section 1876 under
8 this section—

9 “(1) the provisions of such section relating only
10 to individuals enrolled under part B of title XVIII
11 shall not apply;

12 “(2) any reference to a Trust Fund established
13 under title XVIII and to benefits with respect to any
14 services under such title is deemed a reference to the
15 Public Health Trust Fund and to health insurance
16 benefits with respect to required health services
17 under this title;

18 “(3) the adjusted average per capita cost shall
19 be determined on the basis of benefits under this
20 title;

21 “(4) subsections (f) and (h) shall not apply; and

22 “(5) in applying subsection (c)(3)(B), an eligi-
23 ble organization may require a minimum period of
24 enrollment (of not greater than 6 months) during
25 which an individual may not disenroll other than for

1 cause or unless enrollment under this title is termi-
2 nated.

3 **“SEC. 2263. USE OF FISCAL AGENTS.**

4 “(a) USE OF FISCAL AGENTS.—

5 “(1) IN GENERAL.—Except as provided in this
6 section, the Secretary shall provide for the adminis-
7 tration of this title through the use of fiscal agents
8 in the same manner as title XVIII is carried out
9 through the use of such fiscal intermediaries and
10 carriers.

11 “(2) SPECIAL RULES.—In the administration of
12 this title, the Secretary—

13 “(A) may use a single carrier with respect
14 to all required health services in an area, and

15 “(B) shall establish performance standards
16 at least as rigorous as the performance stand-
17 ards applied in the administration of title
18 XVIII.

19 “(3) SEPARATE CONTRACTS.—Contracts with
20 fiscal agents entered into pursuant to this subsection
21 for an area need not be with the same fiscal
22 intermediary or carrier with an agreement under
23 section 1816 or a contract under section 1842 for
24 the area. However, nothing in this section shall be
25 construed as preventing such an organization with

1 such an agreement or contract under such section
2 from entering into a contract under this section.

3 “(b) REQUIRING USE OF ELECTRONIC BILLING.—
4 Effective for claims submitted on or after January 1,
5 1997, payment shall only be made under this title on the
6 basis of bills or charges that are submitted electronically
7 in a manner specified by the Secretary.

8 **“SEC. 2264. GENERAL ADMINISTRATION.**

9 “(a) THROUGH HEALTH CARE FINANCING ADMINIS-
10 TRATION.—Except as otherwise provided in this title, this
11 title shall be administered by the Health Care Financing
12 Administration.

13 “(b) REGULATIONS; TITLE II PROVISIONS; ADMINIS-
14 TRATION.—The provisions of sections 1871, 1872, and
15 1874 (relating to regulations, application of certain provi-
16 sions of title II, and administration) shall apply to this
17 title in the same manner as they apply to title XVIII.

18 “(c) TREATMENT OF AMOUNTS DUE.—In bank-
19 ruptcy and reorganization proceedings, amounts owed to
20 the public health plan under this title shall be treated in
21 the same manner as amounts owed to the Federal Govern-
22 ment under the Federal Insurance Contributions Act.

1 **“SEC. 2265. DETERMINATIONS; APPEALS; PROVIDER REIM-**
2 **BURSEMENT REVIEW BOARD.**

3 “(a) DETERMINATIONS.—The determination of
4 whether an individual is entitled to benefits under this title
5 and the determination of the amount of benefits under this
6 title shall be made by the Secretary in accordance with
7 regulations prescribed by the Secretary.

8 “(b) HEARINGS.—

9 “(1) IN GENERAL.—Any individual dissatisfied
10 with any determination under subsection (a) shall be
11 entitled to a hearing thereon by the Secretary to the
12 same extent as is provided in section 205(b) and to
13 judicial review of the Secretary’s final decision after
14 such hearing as is provided in section 205(g). Sec-
15 tions 206(a), 1102, and 1871 (as incorporated by
16 reference by section 2264) shall not be construed as
17 authorizing the Secretary to prohibit an individual
18 from being represented under this subsection by a
19 person that furnishes the individual, directly or indi-
20 rectly, with services solely on the basis that the per-
21 son furnishes the individual with such a service. Any
22 person that furnishes services to an individual may
23 not represent an individual under this subsection
24 with respect to the issue described in section
25 1879(a)(2) unless the person has waived any rights
26 for payment from the beneficiary with respect to the

1 services involved in the appeal. If a person furnishes
2 services to an individual and represents the individ-
3 ual under this subsection, the person may not im-
4 pose any financial liability on such individual in con-
5 nection with such representation.

6 “(2) LIMITATION.—Notwithstanding paragraph
7 (1), a hearing shall not be available to an individual
8 if the amount in controversy is less than \$500 and
9 judicial review shall not be available to the individual
10 if the amount in controversy is less than \$1,000. In
11 determining the amount in controversy, the Sec-
12 retary, under regulations, shall allow two or more
13 claims to be aggregated if the claims involve the de-
14 livery of similar or involve related services to the
15 same individual or involve common issues of law and
16 fact arising from services furnished to two or more
17 individuals.

18 “(3) EXPEDITED REVIEW.—In an administra-
19 tive hearing pursuant to paragraph (1), where the
20 moving party alleges that there are no material is-
21 sues of fact in dispute, the administrative law judge
22 shall make an expedited determination as to whether
23 any such facts are in dispute and, if not, shall deter-
24 mine the case expeditiously.

1 “(c) PROVIDER REIMBURSEMENT REVIEW BOARD.—
2 The provisions of section 1878 (relating to the Provider
3 Reimbursement Review Board) shall apply under this title
4 in the same manner as they apply under title XVIII.

5 **“SEC. 2266. PROGRAM INTEGRITY; MISCELLANEOUS PROVI-**
6 **SIONS.**

7 “(a) PROGRAM INTEGRITY.—Sections 1124, 1124A,
8 1126, and 1128 through 1128B (relating to fraud and
9 abuse) shall apply to this title in the same manner as they
10 apply to title XVIII.

11 “(b) TITLE XI PROVISIONS.—The following provi-
12 sions shall apply to this title in the same manner as they
13 apply to title XVIII:

14 “(1) Section 1134 (relating to nonprofit hos-
15 pital philanthropy).

16 “(2) Section 1138 (relating to hospital proto-
17 cols for organ procurement and standards for organ
18 procurement agencies).

19 “(c) WITHHOLDING OF PAYMENTS FROM CERTAIN
20 PROVIDERS.—Subsections (a) through (c) of section 1885
21 shall apply to this title, the Secretary, and the Public
22 Health Trust Fund in the same manner as such sub-
23 sections apply to title XIX, the State agency, and the ap-
24 propriate State agency paid funds under subsection (c),
25 respectively.

1 **“SEC. 2267. INFORMATION BY TELEPHONE.**

2 “The Secretary shall provide information via a toll-
3 free telephone number on the public health plan, including
4 information concerning—

5 “(1) the requirement of section 2204, and

6 “(2) low-income assistance under part E.

7 **“SEC. 2268. DEMONSTRATION PROJECT AUTHORITY.**

8 “(a) DEMONSTRATION PROJECT AUTHORITY.—

9 “(1) IN GENERAL.—The Secretary is authorized
10 to conduct demonstration projects—

11 “(A) to improve the delivery and quality of
12 health care services under this title, and

13 “(B) to increase the efficiency and effec-
14 tiveness of methods of payment for such serv-
15 ices.

16 Subject to paragraph (2), the Secretary may waive
17 such requirements of this title as may be necessary
18 to carry out such demonstration projects.

19 “(2) LIMITATION.—The Secretary does not
20 have the authority under paragraph (1)—

21 “(A) to reduce the benefits available under
22 part B, or

23 “(B) to increase the deductibles or coinsur-
24 ance under part C.

1 “(3) FUNDING.—Grants, payments under con-
2 tracts, and other expenditures made for demonstra-
3 tion projects under this subsection—

4 “(A) shall be made from the Public Health
5 Trust Fund,

6 “(B) may be made either in advance or by
7 way of reimbursement, as may be determined
8 by the Secretary, and

9 “(C) shall be made in such installments
10 and on such conditions as the Secretary finds
11 necessary to carry out the purpose of this sub-
12 section.

13 “(b) CONSTRUCTION.—Except as provided in sub-
14 section (a), the Secretary is not authorized to waive any
15 requirement of this title.

16 **“SEC. 2269. INCORPORATION OF MISCELLANEOUS MEDI-**
17 **CARE PROVISIONS.**

18 “(a) OVERPAYMENTS ON BEHALF OF INDIVIDUALS
19 AND SETTLEMENT OF CLAIMS FOR BENEFITS ON BE-
20 HALF OF DECEASED INDIVIDUALS.—The provisions of
21 section 1870 (relating to overpayments on behalf of indi-
22 viduals and settlement of claims for benefits on behalf of
23 deceased individuals), other than subsection (b), shall
24 apply under this title in the same manner as they apply
25 under title XVIII.

1 “(b) LIMITATION ON CERTAIN PHYSICIAN REFER-
2 RALS.—The provisions of section 1877 (relating to limita-
3 tion on certain physician referrals) shall apply under this
4 title in the same manner as they apply under title XVIII.

5 “PART G—[RESERVED]

6 “PART H—DEFINITIONS AND MISCELLANEOUS

7 **“SEC. 2281. INCORPORATION OF CERTAIN DEFINITIONS**
8 **USED IN OTHER HEALTH-RELATED TITLES.**

9 “(a) INCORPORATION OF MEDICARE DEFINITIONS.—
10 In this title, the definitions contained in section 1861
11 apply for purposes of this title in the same manner as they
12 apply for purposes of title XVIII.

13 “(b) INCORPORATION OF CERTAIN EMPLOYMENT-
14 RELATED DEFINITIONS IN TITLE XXI.—In this title, ex-
15 cept as otherwise provided, the definitions of the following
16 terms contained in title XXI apply for purposes of this
17 title:

18 “(1) COVERED EMPLOYER HEALTH PLAN.—The
19 term ‘covered employer health plan’ as defined in
20 section 2121(b).

21 “(2) EMPLOYEE.—The term ‘employee’ as de-
22 fined in section 2181(a)(3).

23 “(3) FULL-TIME EMPLOYEE.—The term ‘full-
24 time employee’ as defined in section 2181(b)(1).

1 “(4) LARGE EMPLOYER.—The term ‘large em-
2 ployer’ as defined in section 2181(c)(3).

3 “(5) MEDIUM-SIZE EMPLOYER.—The term ‘me-
4 dium-size employer’ as defined in section 2181(c)(2).

5 “(6) PART-TIME EMPLOYEE.—The term ‘part-
6 time employee’ as defined in section 2181(b)(2).

7 “(7) QUALIFIED EMPLOYER HEALTH PLAN.—
8 The term ‘qualified employer health plan’ as defined
9 in section 2121(a).

10 “(8) SEASONAL OR TEMPORARY EMPLOYEE.—
11 The term ‘seasonal or temporary employee’ as de-
12 fined in section 2181(b)(3).

13 “(9) SMALL EMPLOYER.—The term ‘small em-
14 ployer’ as defined in section 2181(c)(1).

15 “(10) VERY LARGE EMPLOYER.—The term
16 ‘very large employer’ as defined in section
17 2181(c)(4).

18 “(11) WAGES.—The term ‘wages’ as defined in
19 section 2181(a)(1).

20 **“SEC. 2282. DEFINITIONS RELATING TO FAMILIES.**

21 “In this title:

22 “(1) IN GENERAL.—Except as provided in para-
23 graph (2), the terms ‘family’ and ‘family member’
24 mean an individual and the individual’s spouse, and
25 includes all the individual’s children.

1 “(2) TREATMENT OF FAMILIES WITH MEDI-
2 CARE BENEFICIARIES FOR COVERAGE PURPOSES.—

3 In the case of a family with a medicare beneficiary,
4 if coverage is provided to family members other than
5 on the basis of employment of a family member, the
6 beneficiary shall not be treated under this title as a
7 member of the family for purposes of determining
8 eligibility for coverage but shall be treated as a sepa-
9 rate individual. However, except as provided in sec-
10 tion 2242(b)(2), for purposes of applying part E, a
11 medicare beneficiary shall continue to be treated as
12 a member of the beneficiary’s family.

13 “(3) SPOUSE.—The term ‘spouse’ means, with
14 respect to an individual, the individual to which the
15 individual is married.

16 “(4) MARRIED; UNMARRIED.—Marital status
17 shall be determined in accordance with section 7703
18 of the Internal Revenue Code of 1986.

19 “(5) CHILD.—The term ‘child’ means, with re-
20 spect to a person who is not a child, an individual—

21 “(A) who (i) is unmarried and under 18
22 years of age, (ii) is unmarried and under 23
23 years of age and a full-time student, or (iii) is
24 an unmarried, dependent child, regardless of
25 age, who is incapable of self-support because of

1 mental or physical disability which existed be-
2 fore age 22;

3 “(B)(i) who is the child of the person or
4 the person’s spouse, or

5 “(ii) who is the legal ward of the person or
6 the person’s spouse; and

7 “(C) who is not in the legal custody of an-
8 other individual.

9 The Secretary shall establish, by regulation, such
10 rules as are appropriate with respect to the treat-
11 ment of foster children, emancipated minors, chil-
12 dren in the process of adoption, and other unmar-
13 ried individuals under 23 years of age under similar
14 circumstances as children for purposes of this title.

15 “(6) ADULT.—The term ‘adult’ means an indi-
16 vidual who is not a child.

17 **“SEC. 2283. OTHER DEFINITIONS.**

18 “In this title:

19 “(1) MEDICARE BENEFICIARY; LOW-INCOME
20 MEDICARE BENEFICIARY.—

21 “(A) The term ‘medicare beneficiary’
22 means an individual entitled to benefits under
23 part A of title XVIII.

24 “(B) The term ‘low-income medicare bene-
25 ficiary’ means a medicare beneficiary whose

1 family adjusted total income (as defined in sec-
2 tion 2247(2)), as determined based upon an ap-
3 plication under part E, is less than 200 percent
4 of the official poverty line applicable to a family
5 of the size involved.

6 “(2) OFFICIAL POVERTY LINE.—The term ‘offi-
7 cial poverty line’ means, for an individual in a fam-
8 ily, the official poverty line (as defined by the Office
9 of Management and Budget, and revised annually in
10 accordance with section 673(2) of the Omnibus
11 Budget Reconciliation Act of 1981) applicable to a
12 family of the size involved.

13 “(3) PREGNANT WOMAN.—The term ‘pregnant
14 woman’ means a woman who has been certified by
15 a physician (in a manner specified by the Secretary)
16 as being pregnant, until the last day of the month
17 in which the 60-day period (beginning on the date
18 of termination of the pregnancy) ends.

19 “(4) PUBLIC HEALTH PLAN.—The term ‘public
20 health plan’ means the program of health insurance
21 provided under this title.

1 **“SEC. 2284. AUTHORIZING RECIPROCAL COVERAGE OF FOR-**
2 **EIGN NATIONALS.**

3 “Effective January 1, 1997, the Secretary may make
4 benefits available under this title with respect to required
5 health services for individuals who—

6 “(1) are not eligible individuals described in
7 section 2201(d),

8 “(2) are in the United States, and

9 “(3) are nationals of a foreign state which pro-
10 vides health benefits to nationals of the United
11 States who are in that state,

12 if the Secretary determines that such benefits with respect
13 to such services would be available to nationals of the
14 United States under comparable circumstances in the for-
15 eign state.

16 **“SEC. 2285. NONAPPLICATION TO RESIDENTS OF PUERTO**
17 **RICO AND TERRITORIES.**

18 “The provisions of this title shall not apply to an indi-
19 vidual who is not a resident of one of the 50 States or
20 the District of Columbia.”.

1 **TITLE III—COST CONTAINMENT**
2 **Subtitle A—Health Care Spending**
3 **Amounts**

4 **SEC. 301. SPECIFICATION OF OVERALL HEALTH CARE**
5 **SPENDING AMOUNTS.**

6 (a) AMOUNT.—For purposes of this title, with respect
7 to each year (beginning with 1994), the overall health care
8 spending amount (specified under this section) is the prod-
9 uct of—

10 (1) the average per capita health care expendi-
11 tures (identified in subsection (c)) in previous year,
12 as estimated by the Secretary, multiplied by the ap-
13 plicable adjustment factor for the year involved spec-
14 ified in subsection (b), and

15 (2) the population of the United States (exclud-
16 ing medicare beneficiaries), as projected by the Sec-
17 retary of Commerce as of July 1 of the year in-
18 volved.

19 (b) APPLICABLE ADJUSTMENT FACTOR.—The appli-
20 cable adjustment factor under this subsection for each
21 year is 1 plus the sum (expressed as a fraction) of—

22 (1) the average annual percentage increase in
23 the gross domestic product (in current dollars, as
24 published by the Secretary of Commerce) during the

1 3-year period ending with the second previous year;
2 plus

3 (2)(A) for 1995, 3.5 percentage points,
4 (B) for 1996, 2.5 percentage points,
5 (C) for 1997, 1.5 percentage points,
6 (D) for 1998, 0.5 percentage point, and
7 (E) for each year thereafter, 0 percentage
8 points.

9 (c) SERVICES COVERED.—The average per capita
10 health care expenditures shall be based on the expendi-
11 tures (including expenditures for deductibles and coinsur-
12 ance) for required and other health services (as defined
13 in subsection (d)) expended in the United States, other
14 than with respect to individuals entitled to benefits under
15 part A or B of title XVIII of the Social Security Act.

16 (d) REQUIRED AND OTHER HEALTH SERVICES DE-
17 FINED.—In this subtitle, the term “required and other
18 health services” means required health services, specified
19 in section 2211(a)(2) of the Social Security Act, and also
20 includes prescription drugs, biologicals, and insulin.

21 **SEC. 302. ESTABLISHMENT OF FEDERAL HEALTH CARE**
22 **COST CONTAINMENT COMMISSION.**

23 (a) IN GENERAL.—There is hereby established a
24 Federal Health Care Cost Containment Commission (in
25 this subtitle referred to as the “FHCC”). The FHCC shall

1 be composed of 11 members, appointed by the President
2 by and with the advice and consent of the Senate. The
3 membership of the FHCC shall include individuals with
4 national recognition for their expertise in health econom-
5 ics, health insurance, provider reimbursement, and related
6 fields. In appointing individuals, the President shall assure
7 representation of labor organizations, employers, health
8 care providers, and consumers of health services.

9 (b) TERMS.—Members of the FHCC shall be ap-
10 pointed to serve for terms of 3 years, except that the terms
11 of the members first appointed shall be staggered so that
12 the terms of no more than 4 members expire in any year.
13 Individuals appointed to fill a vacancy created in the
14 FHCC shall be appointed for the remainder of the term.

15 (c) DUTIES RELATING TO ESTABLISHMENT OF PAY-
16 MENT RATES.—

17 (1) ALLOCATION OF OVERALL SPENDING BY
18 STATE.—

19 (A) IN GENERAL.—Each year the FHCC
20 shall apportion the overall health care spending
21 amount specified under section 301 for required
22 and other health services among the States.
23 Subject to subparagraph (B), such apportion-
24 ment shall be based on the populations of the
25 States, adjusted to reflect differences in age

1 and health status of the population and the
2 cost-of-living among the States and such other
3 considerations as the FHCC deems appropriate,
4 including such adjustment as will encourage the
5 provision of necessary services in underserved
6 areas.

7 (B) PHASE-IN.—During the 10-year period
8 beginning in 1994—

9 (i) initially the apportionment shall
10 reflect the current variations in per capita
11 health care expenditures among the States,

12 (ii) gradually the apportionment shall
13 reflect to a lesser degree such current vari-
14 ations, and

15 (iii) at the end of the period the ap-
16 portionment shall reflect only the factors
17 and considerations described in subpara-
18 graph (A).

19 (2) MONITORING STATE EXPENDITURES.—The
20 FHCC shall monitor the compliance of each State
21 with the overall health care spending amount appor-
22 tioned under paragraph (1) for each year and over
23 each 3-year period.

24 (3) APPROVAL OF PAYMENT RATES IN CERTAIN
25 STATES WITHOUT A STATE HEALTH COMMISSION OR

1 UNABLE TO CONTROL HEALTH CARE EXPENDI-
2 TURES.—

3 (A) IN GENERAL.—In the case of a State
4 described in subparagraph (B)—

5 (i) the FHCC shall conduct negotia-
6 tions with professional and other associa-
7 tions representing the types of health care
8 providers in order to apportion the overall
9 health care spending apportioned to the
10 States under paragraph (1) among the dif-
11 ferent classes of providers (as defined in
12 subsection (f));

13 (ii) the Secretary shall establish, for
14 each class of provider for the year involved
15 and subject to approval by the FHCC
16 under clause (iii), payment rates for re-
17 quired and other health services consistent
18 with the limitation on overall health care
19 spending for such services specified in sub-
20 paragraph (B)(ii) and reflecting such re-
21 duction in payment rates as may be nec-
22 essary to reduce spending by an amount
23 equal to the amount by which the State
24 has exceeded such spending limitation; and

1 (iii) the FHCC shall review and, if
2 they meet the standards described in sec-
3 tion 304(a), approve the payment rates es-
4 tablished by the Secretary under clause (ii)
5 or, if they do not, disapprove such rates.

6 (B) STATES COVERED.—A State is de-
7 scribed in this subparagraph if the FHCC de-
8 termines that the State—

9 (i) has failed to establish a State
10 Health Commission in accordance with sec-
11 tion 303(a), or

12 (ii) has permitted over a 3-consecu-
13 tive-year period overall health care spend-
14 ing for required and other health services
15 in the State to exceed the sum of—

16 (I) the cumulative overall health
17 care spending amount apportioned to
18 the State under paragraph (1) for
19 that period and

20 (II) any cumulative difference be-
21 tween a State's overall health care
22 spending for required and other
23 health services in previous periods and
24 spending amounts apportioned to the

1 State under paragraph (1) for those
2 periods,
3 until such time as the FHCC determines that
4 such a State Health Commission has been es-
5 tablished and that the State has provided the
6 FHCC with satisfactory assurances that overall
7 health care spending for required and other
8 health services in the State will not exceed the
9 overall health care spending amount appor-
10 tioned to the State under paragraph (1).

11 (C) PAYMENT BASIS.—The payment rates
12 established under subparagraph (A)(ii) shall be
13 based on payment methodologies (including
14 payment for inpatient hospital services on the
15 basis of per discharge payments relating to di-
16 agnosis-related groups and payment for physi-
17 cians' services based on a resource-based rel-
18 ative value scale) used under title XVIII of the
19 Social Security Act. In establishing such rates,
20 the Secretary shall consult with the Prospective
21 Payment Assessment Commission and with the
22 Physician Payment Review Commission, as ap-
23 propriate.

24 (D) APPLICATION OF RATES.—

1 (i) IN GENERAL.—Except as provided
2 in clause (ii), the rates established under
3 subparagraph (B)(ii) shall be the rate that
4 may be charged by providers under quali-
5 fied employer health plans or under the
6 public health plan.

7 (ii) SPECIAL TREATMENT OF PHYSI-
8 CIANS' SERVICES.—In applying subpara-
9 graph (E) in the case of physicians' serv-
10 ices, the rate specified under this para-
11 graph shall be the same percentage above
12 the rate otherwise computed under this
13 paragraph as the percentage by which the
14 limiting charge under section 1848(g) of
15 the Social Security Act exceeds the recog-
16 nized payment amount (as defined in sec-
17 tion 1848(g)(2)(D) of such Act).

18 (E) ENFORCEMENT.—Any health care pro-
19 vider that imposes a charge in excess of the
20 rate specified under this paragraph shall be in-
21 eligible for a period (specified by the Secretary)
22 of not more than 5 years to provide services for
23 which payment may be made under title XVIII,
24 XIX, or XXII of the Social Security Act.

1 (4) APPEALS OF PAYMENT RATES ESTAB-
2 LISHED BY STATE HEALTH COMMISSIONS.—

3 (A) PROCESS.—The FHCC shall establish
4 a process for receipt of, and action upon, griev-
5 ances concerning payment rates established by
6 a State Health Commission under section 303.
7 Such process shall provide for disapproval of
8 such a rate if the rate fails to meet the stand-
9 ards for approval of such a rate under section
10 304(a).

11 (B) RATE ADJUSTMENTS.—In the case of
12 such a disapproval, the SHC shall revise rates
13 consistent with such standards.

14 (d) PERIODIC REPORTS.—The FHCC shall report to
15 the Congress and the public periodically (not less often
16 than annually) on the effect of this title on the delivery
17 of required health care services.

18 (e) MISCELLANEOUS.—

19 (1) AUTHORITY.—The FHCC shall have the
20 authority specified in clauses (i) through (vi) of sec-
21 tion 1886(e)(6)(C) of the Social Security Act, but
22 (under such clause (i)) not subject to the approval
23 of the Director of the Office.

24 (2) COMPENSATION.—While serving on the
25 business of the FHCC (including traveltime), a

1 member of the FHCC shall be entitled to compensa-
2 tion at the per diem equivalent of the rate provided
3 for level IV of the Executive Schedule under section
4 5315 of title 5, United States Code; and while so
5 serving away from home and his regular place of
6 business, a member may be allowed travel expenses,
7 as authorized by the Chairman of the FHCC. Physi-
8 cians serving as personnel of the FHCC may be pro-
9 vided a physician comparability allowance by the
10 FHCC in the same manner as Government physi-
11 cians may be provided such an allowance by an
12 agency under section 5948 of title 5, United States
13 Code, and for such purpose subsection (i) of such
14 section shall apply to the FHCC in the same manner
15 as it applies to the Tennessee Valley Authority.

16 (3) ACCESS TO INFORMATION, ETC.—The provi-
17 sions of subparagraphs (F) and (H) of section
18 1886(e)(6) of the Social Security Act shall apply to
19 the FHCC in the same manner as they apply to the
20 Prospective Payment Assessment Commission.

21 (4) AUTHORIZATION OF APPROPRIATIONS.—
22 There are authorized to be appropriated, from the
23 Public Health Trust Fund (established under section
24 2233 of the Social Security Act) such sums as may
25 be necessary to carry out this section.

1 (f) CLASS OF PROVIDER DEFINED.—In this subtitle,
2 the term “class of provider” means hospitals, physicians,
3 and such other classes of health care providers (which may
4 include a prepaid system of health care delivery) as the
5 FHCC specifies in regulations.

6 (g) SECRETARY.—In this subtitle, the term “Sec-
7 retary” means the Secretary of Health and Human Serv-
8 ices.

9 **SEC. 303. STATE HEALTH RATE COMMISSIONS.**

10 (a) IN GENERAL.—Each State shall establish a State
11 Health Commission (each in this section referred to as a
12 “SHC”) to carry out duties under this section. If a State
13 fails to establish such a SHC, the FHCC shall perform
14 functions of such a Commission under section 302(c)(3).

15 (b) COMPOSITION AND TERMS.—

16 (1) COMPOSITION.—Each SHC shall be com-
17 posed of not to exceed 11 members, appointed by the
18 chief executive officer of the State. The membership
19 of each SHC shall include individuals with recogni-
20 tion for their expertise in health economics, health
21 insurance, provider reimbursement, and related
22 fields. In appointing individuals, the chief executive
23 officer shall assure representation of labor organiza-
24 tions, employers, health care providers, and consum-
25 ers of health services.

1 (2) TERMS.—Members of each SHC shall be
2 appointed to serve for terms of 3 years, except that
3 the terms of the members first appointed shall be
4 staggered so that the terms of no more than 40 per-
5 cent of the number of members expire in any year.
6 Individuals appointed to fill a vacancy created in an
7 SHC shall be appointed for the remainder of the
8 term.

9 (c) DUTIES.—

10 (1) ALLOCATION OF OVERALL SPENDING BY
11 STATE.—Each year each SHC shall apportion the
12 portion of the health care spending amount appor-
13 tioned to the State under section 302(c)(1) among
14 required and other health services furnished by the
15 different classes of providers.

16 (2) ESTABLISHMENT OF PAYMENT RATES.—

17 (A) IN GENERAL.—Each year each SHC
18 shall establish for each such class of provider
19 payment rates for required and other health
20 services (as defined in section 301(d)) furnished
21 in that State in that year, which meet the
22 standards for approval under section 304(a).

23 (B) REVISION OF RATES.—If the FHCC
24 determines that particular payment rates do not
25 meet the standard specified under section

1 304(a)(2) and must be increased to meet such
2 standard, the SHC—

3 (i) shall increase those payment rates
4 so as to meet such standard, and

5 (ii) shall provide for such decrease in
6 other payment rates as may be necessary
7 to assure that the standard described in
8 section 304(a)(1) continues to be met (tak-
9 ing into account the increase provided
10 under clause (i)).

11 (3) USE OF REGIONAL COMMISSIONS IN CARRY-
12 ING OUT DUTIES.—In carrying out duties of an SHC
13 under this subsection, a State may establish regional
14 commissions to carry out the functions of the SHC
15 on a local basis, within the allocation provided to the
16 region by the SHC.

17 **SEC. 304. STANDARD FOR PAYMENT RATES.**

18 (a) IN GENERAL.—The FHCC shall approve rates es-
19 tablished by a State Health Commission (or regional com-
20 mission) under section 303(c)(2), or the Secretary under
21 section 302(c)(3)(A)(ii), for a class of provider only if the
22 FHCC determines that—

23 (1) the rates, if applied in the aggregate by all
24 qualified employer health plans and by the public
25 health plan during the year in the State, would re-

1 sult in total expenditures for required services fur-
2 nished by that class of provider that are consistent
3 with the amount distributed under section 303(c)(1)
4 or 302(c)(3)(A)(i), as the case may be, for services
5 of that class of provider; and

6 (2) the rates are reasonable and adequate, con-
7 sistent with subsection (b).

8 (b) TEST OF REASONABLENESS AND ADEQUACY.—
9 For purposes of applying subsection (a)(2) with respect
10 to payment rates for required and other health services
11 furnished by a class of provider—

12 (1) ACCESS AND QUALITY.—Payment rates are
13 not considered to be reasonable and adequate if pa-
14 tients will not have reasonable access to services of
15 high quality.

16 (2) AGGREGATE ADEQUACY.—The determina-
17 tion of reasonableness and adequacy of payment
18 rates shall be made based on the aggregate rates.

19 (3) EQUITABLE RATE DISTRIBUTION.—Pay-
20 ment rates are not considered to be reasonable un-
21 less they are set equitably among all purchasers
22 without undue discrimination.

23 (4) APPROPRIATE SETTING.—Payment rates
24 are not considered to be reasonable and adequate
25 unless the rates—

1 (A) encourage services to be provided to
2 patients in the most cost effective environment
3 that does not endanger patients' well-being, and

4 (B) include incentives to contain health
5 care costs.

6 The payment rates may be designed to encourage the pro-
7 vision of necessary services in underserved areas.

8 **SEC. 305. APPLICATION OF RATES UNDER MEDICARE AND**
9 **PUBLIC PROGRAMS.**

10 Payment rates approved this subtitle shall apply both
11 under the medicare program under title XVIII of the So-
12 cial Security Act and under the public health plan under
13 title XXII of such Act.

14 **Subtitle B—Administrative**
15 **Simplification**

16 **SEC. 321. REQUIREMENT FOR UNIFORM HEALTH CLAIMS**
17 **CARDS.**

18 (a) UNIFORM HEALTH CLAIMS CARDS.—

19 (1) REQUIREMENT.—Each health benefit plan
20 (as defined in section 326(a)) shall issue a health
21 claims card that meets the requirements of sub-
22 section (c) for each individual who is entitled to ben-
23 efits under the plan and who is residing in the Unit-
24 ed States. Such card shall be issued to the individual
25 involved or, in the case of an individual enrolled as

1 a dependent of another individual, to that other indi-
2 vidual.

3 (2) DEADLINE FOR APPLICATION OF REQUIRE-
4 MENT.—The deadline specified under this paragraph
5 for the requirement under paragraph (1) is 6
6 months after the date the standards are established
7 under subsection (c).

8 (b) ENFORCEMENT THROUGH CIVIL MONEY PEN-
9 ALTIES.—

10 (1) IN GENERAL.—In the case of a health bene-
11 fit plan that fails to issue a health claims card in ac-
12 cordance with subsection (a)(1), the plan is subject
13 to a civil money penalty of not to exceed \$100 for
14 each such violation. The provisions of section 1128A
15 of the Social Security Act (other than subsections
16 (a) and (b)) shall apply to a civil money penalty
17 under this subsection in the same manner as such
18 provisions apply to a penalty or proceeding under
19 section 1128A(a) of such Act.

20 (2) EFFECTIVE DATE.—No penalty may be im-
21 posed under paragraph (1) for any failure occurring
22 before the deadline specified in subsection (a)(2).

23 (c) UNIFORM HEALTH CLAIMS CARDS.—

24 (1) IN GENERAL.—The Secretary shall establish
25 standards consistent with this subsection respecting

1 the form and information to be contained on uni-
2 form health claims cards (for purposes of subsection
3 (a)).

4 (2) ELECTRONIC.—

5 (A) IN GENERAL.—Subject to subpara-
6 graph (B), the card shall be in a form similar
7 to that of a credit card and shall have, encoded
8 in electronic form—

9 (i) the identity of the individual,

10 (ii) the health benefit plan in which
11 the individual is enrolled, and

12 (iii) the telephone number or numbers
13 to be used for the verification electronically
14 of entitlement to benefits under the plan
15 under section 322 and for the submission
16 electronically of claims under the plan
17 under section 323.

18 (B) USE OF ELECTRONIC READ-AND-
19 WRITE CARDS.—The Secretary may provide for
20 cards in a electronic form that permits informa-
21 tion on the card to be readily changed. Such in-
22 formation may include information relating to
23 the health coverage status of the individual and
24 the medical history of the individual.

1 (C) PERSONAL IDENTIFIER.—For pur-
2 poses of subparagraph (A) and for purposes of
3 claims processing and related purposes under
4 section 323, the Social Security account number
5 of the individual or, in the case of an infant or
6 other individual to whom such a number has
7 not been issued, such a Social Security account
8 number of a parent or guardian or other num-
9 ber as the Secretary shall specify, shall be used
10 as the personal identifier for the individual.

11 (3) ADDITIONAL INFORMATION.—The card
12 shall include such additional information, in elec-
13 tronic or other form, as the Secretary may require
14 to carry out the purposes of this Act. In addition,
15 the health benefit plan issuing the card may include
16 such additional information on the card as the plan
17 desires, subject to such limitations as the Secretary
18 may provide.

19 (4) DEADLINE.—The Secretary shall first es-
20 tablish the standards for uniform health claims
21 cards under this subsection by not later than 12
22 months after the date of the enactment of this Act.

23 (d) APPLICATION TO MEDICARE AND MEDICAID PRO-
24 GRAMS.—

1 (1) MEDICARE PROGRAM.—The Secretary shall
2 provide, in regulations promulgated to carry out the
3 medicare program, that identification cards issued
4 under that program are modified to the extent re-
5 quired to conform to the standards established under
6 subsection (c), by not later than the deadline speci-
7 fied in subsection (a)(2).

8 (2) STATE MEDICAID PLANS.—As a condition
9 for the approval of a State plan under the medicaid
10 program, effective for calendar quarters beginning
11 on or after the deadline specified in subsection
12 (a)(2), each such plan shall provide, in accordance
13 with regulations of the Secretary, that identification
14 cards issued under the plan are modified to the ex-
15 tent required to conform to the requirements of sub-
16 section (c).

17 **SEC. 322. REQUIREMENT FOR ENTITLEMENT VERIFICA-**
18 **TION SYSTEM.**

19 (a) IN GENERAL.—

20 (1) REQUIREMENT.—Each health benefit plan
21 shall provide for an electronic system, that is cer-
22 tified by the Secretary as meeting the standards es-
23 tablished under subsection (c), for the verification of
24 an individual's entitlement to benefits under such
25 plan.

1 (2) DEADLINE FOR APPLICATION OF REQUIRE-
2 MENT.—The deadline specified under this paragraph
3 for the requirement under paragraph (1) is 6
4 months after the date the standards are established
5 under subsection (c).

6 (b) ENFORCEMENT THROUGH CIVIL MONEY PEN-
7 ALTIES.—

8 (1) IN GENERAL.—In the case of a health bene-
9 fit plan that fails to provide for an electronic ver-
10 ification system that is certified by the Secretary as
11 meeting the standards established under subsection
12 (c), the plan is subject to a civil money penalty of
13 not to exceed \$100 for each day in which such fail-
14 ure persists. The provisions of section 1128A of the
15 Social Security Act (other than subsections (a) and
16 (b)) shall apply to a civil money penalty under this
17 subsection in the same manner as such provisions
18 apply to a penalty or proceeding under section
19 1128A(a) of such Act.

20 (2) EFFECTIVE DATE.—No penalty may be im-
21 posed under paragraph (1) for any failure occurring
22 before the deadline specified in subsection (a)(2).

23 (c) STANDARDS FOR ENTITLEMENT VERIFICATION
24 SYSTEMS.—

1 (1) IN GENERAL.—The Secretary shall estab-
2 lish standards consistent with this subsection re-
3 specting the requirements for certification of entitle-
4 ment verification systems.

5 (2) INFORMATION AVAILABLE.—Such standards
6 shall require a system to provide information, with
7 respect to individuals, concerning the following:

8 (A) The specific benefits to which the indi-
9 vidual is entitled under the plan.

10 (B) Current status of the individual with
11 respect to fulfillment of deductibles,
12 copayments, and out-of-pocket limits on cost-
13 sharing.

14 (C) Restrictions on providers who may pro-
15 vide covered services, including utilization con-
16 trols (such as preadmission certification).

17 (3) COORDINATION OF BENEFIT INFORMA-
18 TION.—Such standards shall require a system to
19 provide for the transfer among health benefit plans
20 of appropriate information in determining liability in
21 cases in which benefits may be payable under two or
22 more such plans.

23 (4) FORM OF INQUIRY.—Each verification sys-
24 tem shall be capable of accepting inquiries under
25 this subsection from health care providers (and, to

1 the extent provided under paragraph (3), from other
2 health benefit plans) in a variety of electronic and
3 other forms, including—

4 (A) through electronic transmission of in-
5 formation on the uniform health claims card (in
6 a manner similar to that for verification of
7 credit card purchases),

8 (B) through the use of a touch-tone tele-
9 phone line, and

10 (C) through the use of a computer modem.

11 The system shall also provide, for an additional fee,
12 for the acceptance of inquiries in a nonelectronic
13 form.

14 (5) FORM OF RESPONSE.—Each such system
15 shall be capable of responding to such inquiries
16 under this subsection in a variety of electronic and
17 other forms, including—

18 (A) through modem transmission of infor-
19 mation,

20 (B) through computer synthesized voice
21 communication, and

22 (C) through transmission of information to
23 a facsimile (fax) machine.

24 The system shall also provide, for an additional fee,
25 for the response to inquiries in a nonelectronic form.

1 (6) LIMITATION ON FEES.—A health benefit
2 plan may not impose a fee for the acceptance or re-
3 sponse to an inquiry under this subsection except
4 where the acceptance or response is in a
5 nonelectronic form.

6 (7) PUBLIC DOMAIN SOFTWARE TO PROVID-
7 ERS.—The Secretary shall provide for the develop-
8 ment, and shall make available without charge to
9 health service providers and health benefit plans,
10 such computer software as will enable—

11 (A) such providers to make inquiries, and
12 receive responses, electronically respecting the
13 eligibility and benefits of an individual under
14 health benefit plans, and

15 (B) such plans to make inquiries, and re-
16 ceive responses, electronically respecting liability
17 of other plans for the provision or payment of
18 benefits.

19 (8) DEADLINE.—The Secretary shall first es-
20 tablish the standards under this subsection (and
21 shall develop and make available the software under
22 paragraph (7)) by not later than 12 months after
23 the date of the enactment of this Act.

24 (d) APPLICATION TO MEDICARE AND MEDICAID PRO-
25 GRAMS.—

1 (1) MEDICARE PROGRAM.—The Secretary shall
2 provide, in regulations promulgated to carry out the
3 medicare program, that there is established an enti-
4 tlement verification system that meets the standards
5 established under subsection (c), by not later than
6 the deadline specified in subsection (a)(2).

7 (2) STATE MEDICAID PLANS.—As a condition
8 for the approval of a State plan under the medicaid
9 program, effective for calendar quarters beginning
10 on or after the deadline specified in subsection
11 (a)(2), each such plan shall provide, in accordance
12 with regulations of the Secretary, that there is es-
13 tablished an entitlement verification system that
14 meets the standards established under subsection
15 (c).

16 **SEC. 323. REQUIREMENTS FOR UNIFORM CLAIMS AND**
17 **ELECTRONIC CLAIMS DATA SET.**

18 (a) REQUIREMENTS.—

19 (1) SUBMISSION OF CLAIMS.—Each health serv-
20 ice provider that furnishes services in the United
21 States for which payment may be made under a
22 health benefit plan shall submit any claim for pay-
23 ment for such services only in a form and manner
24 consistent with standards established under sub-
25 section (c).

1 (2) ACCEPTANCE OF CLAIMS.—A health benefit
2 plan may not reject a claim for payment under the
3 plan on the basis of the form or manner in which
4 the claim is submitted if the claim is submitted in
5 accordance with the standards established under
6 subsection (c).

7 (3) EFFECTIVE DATE.—This subsection shall
8 apply to claims for services furnished on or after the
9 date that is 6 months after the date standards are
10 established under subsection (c).

11 (b) ENFORCEMENT THROUGH CIVIL MONEY PEN-
12 ALTIES.—

13 (1) IN GENERAL.—

14 (A) PROVIDERS.—In the case of a health
15 service provider that submits a claim in viola-
16 tion of subsection (a)(1), the provider is subject
17 to a civil money penalty of not to exceed \$100
18 (or, if greater, the amount of the claim) for
19 each such violation.

20 (B) PLANS.—In the case of a health bene-
21 fit plan that rejects a claim in violation of sub-
22 section (a)(2), the plan is subject to a civil
23 money penalty of not to exceed \$100 (or, if
24 greater, the amount of the claim) for each such
25 violation.

1 (2) PROCESS.—The provisions of section 1128A
2 of the Social Security Act (other than subsections
3 (a) and (b)) shall apply to a civil money penalty
4 under paragraph (1) in the same manner as such
5 provisions apply to a penalty or proceeding under
6 section 1128A(a) of such Act.

7 (3) SUNSET FOR PENALTY.—No civil money
8 penalty may be imposed under this subsection for
9 submission (or rejection) of any claim on or after
10 the date that is 36 months after the effective date
11 specified in subsection (a)(3).

12 (c) STANDARDS RELATING TO UNIFORM CLAIMS AND
13 ELECTRONIC CLAIMS DATA SET.—

14 (1) ESTABLISHMENT OF STANDARDS.—The
15 Secretary shall establish standards that—

16 (A) relate to the form and manner of sub-
17 mission of claims for benefits under a health
18 benefit plan, and

19 (B) define the data elements to be con-
20 tained in a uniform electronic claims data set to
21 used with respect to such claims.

22 (2) SCOPE OF INFORMATION.—

23 (A) IN GENERAL.—The standards under
24 this subsection are intended to cover substan-
25 tially most claims that are filed under health

1 benefit plans. Such information need not in-
2 clude all elements that may potentially be re-
3 quired to be reported under utilization review
4 provisions of plans.

5 (B) ENSURING ACCOUNTABILITY FOR
6 CLAIMS SUBMITTED ELECTRONICALLY.—In es-
7 tablishing such standards, the Secretary, in
8 consultation with appropriate agencies, shall in-
9 clude such methods of ensuring provider re-
10 sponsibility and accountability for claims sub-
11 mitted electronically that are designed to con-
12 trol fraud and abuse in the submission of such
13 claims.

14 (C) COMPONENTS.—In establishing such
15 standards the Secretary shall—

16 (i) with respect to data elements, de-
17 fine data fields, formats, and medical no-
18 menclature, and plan benefit and insurance
19 information;

20 (ii) develop a single, uniform coding
21 system for diagnostic and procedure codes;
22 and

23 (iii) provide for standards for the uni-
24 form electronic transmission of such ele-
25 ments.

1 (3) COORDINATION WITH STANDARDS FOR
2 ELECTRONIC MEDICAL RECORDS.—In establishing
3 standards under this subsection, the Secretary shall
4 assure that—

5 (A) the development of such standards is
6 coordinated with the development of the stand-
7 ards for electronic medical records under sec-
8 tion 324, and

9 (B) the coding of data elements under the
10 uniform electronic claims data set and the cod-
11 ing of the same elements in the uniform hos-
12 pital clinical data set are consistent.

13 (4) USE OF TASK FORCES.—In adopting stand-
14 ards under this subsection—

15 (A) the Secretary shall take into account
16 the recommendations of current task forces, in-
17 cluding at least the Workgroup on Electronic
18 Data Interchange, National Uniform Billing
19 Committee, the Uniform Claim Task Force, and
20 the Computer-based Patient Record Institute,
21 and

22 (B) the Secretary shall provide that the
23 electronic transmission standards are consist-
24 ent, to the extent practicable, with the applica-
25 ble standards established by the Accredited

1 Standards Committee X-12 of the American
2 National Standards Institute.

3 (5) UNIFORM, UNIQUE PROVIDER IDENTIFICA-
4 TION CODES.—In establishing standards under this
5 subsection—

6 (A) the Secretary shall provide for a
7 unique identifier code for each health service
8 provider that furnishes services for which a
9 claim may be submitted under a health benefit
10 plan, and

11 (B) in the case of a provider that has a
12 unique identifier issued for purposes of the
13 medicare program, the code provided under
14 subparagraph (A) shall be the same as such
15 unique identifier.

16 (6) PUBLIC DOMAIN SOFTWARE TO PROVID-
17 ERS.—The Secretary shall provide for the develop-
18 ment, and shall make available without charge to
19 health service providers, such computer software as
20 will enable the providers to submit claims and to re-
21 ceive verification of claims status electronically.

22 (7) STANDARDS FOR PAPER CLAIMS.—The
23 standards shall provide for a uniform paper claims
24 form which is consistent with data elements required
25 for the submission of claims electronically.

1 (8) STANDARDS FOR CLAIMS FOR CLINICAL
2 LABORATORY TESTS.—The standards shall provide
3 that claims for clinical laboratory tests for which
4 benefits are provided under a health benefit plan
5 shall be submitted directly by the person or entity
6 that performed (or supervised the performance of)
7 the tests to the plan in a manner consistent with
8 (and subject to such exceptions as are provided
9 under) the requirement for direct submission of such
10 claims under the medicare program.

11 (9) DEADLINE.—The Secretary shall first pro-
12 vide for the standards for the uniform claims under
13 this subsection (and shall develop and make avail-
14 able the software under paragraph (6)) by not later
15 than 1 year after the date of the enactment of this
16 Act.

17 (d) USE UNDER MEDICARE AND MEDICAID PRO-
18 GRAMS.—

19 (1) REQUIREMENT FOR PROVIDERS.—In the
20 case of a health service provider that submits a
21 claim for services furnished under the medicare pro-
22 gram or medicaid program in violation of subsection
23 (a)(1), no payment shall be made under such pro-
24 gram for such services.

1 (2) REQUIREMENTS OF INTERMEDIARIES AND
2 CARRIERS UNDER MEDICARE PROGRAM.—The Sec-
3 retary shall provide, in regulations promulgated to
4 carry out title XVIII of the Social Security Act, that
5 the claims process provided under that title is modi-
6 fied to the extent required to conform to the stand-
7 ards established under subsection (c).

8 (3) REQUIREMENTS OF STATE MEDICAID
9 PLANS.—As a condition for the approval of State
10 plans under the medicaid program, effective as of
11 the effective date specified in subsection (a)(3), each
12 such plan shall provide, in accordance with regula-
13 tions of the Secretary, that the claims process pro-
14 vided under the plan is modified to the extent re-
15 quired to conform to the standards established under
16 subsection (c).

17 **SEC. 324. ELECTRONIC MEDICAL RECORDS AND REPORT-**
18 **ING.**

19 (a) STANDARDS FOR ELECTRONIC MEDICAL
20 RECORDS FOR HOSPITALS.—

21 (1) PROMULGATION OF STANDARDS.—

22 (A) IN GENERAL.—Between July 1, 1994,
23 and January 1, 1995, the Secretary shall pro-
24 mulgate standards described in paragraph (2)

1 for hospitals concerning electronic medical
2 records.

3 (B) REVISION.—The Secretary may from
4 time to time revise the standards promulgated
5 under this paragraph.

6 (2) CONTENTS OF STANDARDS.—The standards
7 promulgated under paragraph (1) shall include at
8 least the following:

9 (A) A definition of a uniform hospital clinical
10 data set, including a definition of the set of
11 comprehensive data elements, for use by utilization
12 and quality control peer review organizations.
13

14 (B) Standards for an electronic patient
15 care information system with data obtained at
16 the point of care.

17 (C) A specification of, and manner of presentation
18 of, the individual data elements of the
19 set and system under this paragraph.

20 (D) Standards concerning the transmission
21 of electronic medical data.

22 (E) Standards relating to confidentiality of
23 patient-specific information, which include the
24 physical security of electronic data and the use
25 of keys, passwords, encryption, and other

1 means to ensure the protection of the confiden-
2 tiality and privacy of electronic data.

3 (3) COORDINATION WITH STANDARDS FOR UNI-
4 FORM ELECTRONIC CLAIMS DATA SET.—In establish-
5 ing standards under this subsection, the Secretary
6 shall assure that—

7 (A) the development of such standards is
8 coordinated with the development of the stand-
9 ards for the uniform electronic claims data set
10 under section 323, and

11 (B) the coding of data elements under the
12 uniform hospital clinical data set and the cod-
13 ing of the same elements under the uniform
14 electronic claims data set are consistent.

15 (4) CONSULTATION.—in establishing standards
16 under this subsection, the Secretary shall—

17 (A) consult with the American National
18 Standards Institute, hospitals, health benefit
19 plans, and other interested parties, and

20 (B) take into consideration, in developing
21 standards under paragraph (2)(A), the data set
22 used by the utilization and quality control peer
23 review program under part B of title XI of the
24 Social Security Act.

1 (b) REQUIREMENT FOR APPLICATION OF ELEC-
2 TRONIC RECORDS STANDARDS TO HOSPITALS.—

3 (1) AS CONDITION OF MEDICARE PARTICIPA-
4 TION.—As of January 1, 1996, each hospital, as a
5 requirement of each participation agreement under
6 section 1866 of the Social Security Act, shall, in ac-
7 cordance with the standards promulgated under sub-
8 section (a)(1)—

9 (A) maintain clinical data included in the
10 uniform hospital clinical data set under sub-
11 section (a)(2)(A) in electronic form on all inpa-
12 tients,

13 (B) upon request of the Secretary or of a
14 utilization and quality control peer review orga-
15 nization (with which the Secretary has entered
16 into a contract under part B of title XI of such
17 Act), transmit electronically data requested
18 from such data set, and

19 (C) upon request of the Secretary, or of a
20 fiscal intermediary or carrier, transmit elec-
21 tronically any data (with respect to a claim)
22 from such data set.

23 (2) APPLICATION OF PRESENTATION AND
24 TRANSMISSION STANDARDS TO ELECTRONIC TRANS-
25 MISSION TO FEDERAL AGENCIES.—Effective Janu-

1 ary 1, 1996, if a hospital is required under a Fed-
2 eral program to transmit a data element that is sub-
3 ject to a standard, promulgated under subsection
4 (a)(1), described in subparagraph (C) or (D) of sub-
5 section (a)(2), the head of the Federal agency re-
6 sponsible for such program (if not otherwise author-
7 ized) is authorized to require the provider to present
8 and transmit the data element electronically in ac-
9 cordance with such a standard.

10 (c) LIMITATION ON DATA REQUIREMENTS WHERE
11 STANDARDS IN EFFECT.—

12 (1) IN GENERAL.—On or after January 1,
13 1996, a health benefit plan may not require, for the
14 purpose of utilization review or as a condition of
15 providing benefits or making payments under the
16 plan, that a hospital—

17 (A) provide any data element not in the
18 uniform hospital clinical data set specified
19 under the standards promulgated under sub-
20 section (a), or

21 (B) transmit or present any such data ele-
22 ment in a manner inconsistent with such stand-
23 ards applicable to such transmission or presen-
24 tation.

1 (2) COMPLIANCE.—The Secretary may impose
2 a civil money penalty on any health benefit plan that
3 fails to comply with paragraph (1) in an amount not
4 to exceed \$100 for each such failure. The provisions
5 of section 1128A of the Social Security Act (other
6 than the first sentence of subsection (a) and other
7 than subsection (b)) shall apply to a civil money
8 penalty under this paragraph in the same manner as
9 such provisions apply to a penalty or proceeding
10 under section 1128A(a) of such Act.

11 (3) APPLICATION TO MEDICARE PROGRAM.—Ef-
12 fective as of January 1, 1996, neither the Secretary,
13 nor any carrier or fiscal intermediary, nor any utili-
14 zation and quality control peer review organization
15 may require, for the purpose of utilization review or
16 as a condition of providing benefits or making pay-
17 ments under the medicare program, that a hos-
18 pital—

19 (A) provide any data element not in the
20 uniform hospital clinical data set specified
21 under the standards promulgated under sub-
22 section (a), or

23 (B) transmit or present any such data ele-
24 ment in a manner inconsistent with such stand-

1 ards applicable to such transmission or presen-
2 tation.

3 (4) APPLICATION TO MEDICAID PROGRAM.—As
4 a condition for the approval of State plans under the
5 medicaid program and in accordance with regula-
6 tions of the Secretary, effective as of January 1,
7 1996, each such plan may not require that a hos-
8 pital, for the purpose of utilization review or as a
9 condition of providing benefits or making payments
10 under the plan—

11 (A) provide any data element not in the
12 uniform hospital clinical data set specified
13 under the standards promulgated under sub-
14 section (a), or

15 (B) transmit or present any such data ele-
16 ment in a manner inconsistent with such stand-
17 ards applicable to such transmission or presen-
18 tation.

19 (d) PREEMPTION OF STATE QUILL PEN LAWS.—

20 (1) IN GENERAL.—Any provision of State law
21 that requires medical or health insurance records
22 (including billing information) to be maintained in
23 written, rather than electronic, form shall be deemed
24 to be satisfied if the records are maintained in an

1 electronic form that meets standards established by
2 the Secretary under paragraph (2).

3 (2) SECRETARIAL AUTHORITY.—Not later than
4 1 year after the the date of the enactment of this
5 Act, the Secretary shall issue regulations to carry
6 out paragraph (1). The regulations shall provide for
7 an electronic substitute that is in the form of a
8 unique identifier (assigned to each authorized indi-
9 vidual) that serves the functional equivalent of a sig-
10 nature. The regulations may provide for such excep-
11 tions to paragraph (1) as the Secretary determines
12 to be necessary to prevent fraud and abuse, to pre-
13 vent the illegal distribution of controlled substances,
14 and in such other cases as the Secretary deems ap-
15 propriate.

16 (3) EFFECTIVE DATE.—Paragraph (1) shall
17 take effect on the first day of the first month that
18 begins more than 30 days after the date the Sec-
19 retary issues the regulations referred to in para-
20 graph (2).

21 **SEC. 325. UNIFORM HOSPITAL COST REPORTING.**

22 Each hospital, as a requirement under a participation
23 agreement under section 1866(a) of the Social Security
24 Act for each cost reporting period beginning during or
25 after fiscal year 1993, shall provide for the reporting of

1 information to the Secretary with respect to any hospital
2 care provided in a uniform manner consistent with stand-
3 ards established by the Secretary to carry out section
4 4007(c) of the Omnibus Budget Reconciliation Act of
5 1987 and in an electronic form consistent with standards
6 established by Secretary.

7 **SEC. 326. DEFINITIONS.**

8 (a) HEALTH BENEFIT PLAN.—In this subtitle:

9 (1) IN GENERAL.—The term “health benefit
10 plan” means, except as provided in paragraphs (2)
11 through (4), any public or private entity or program
12 that provides for payments for health care services,
13 including—

14 (A) a group health plan (as defined in sec-
15 tion 5000(b)(1) of the Internal Revenue Code
16 of 1986), and

17 (B) any other health insurance arrange-
18 ment, including any arrangement consisting of
19 a hospital or medical expense incurred policy or
20 certificate, hospital or medical service plan con-
21 tract, or health maintenance organization sub-
22 scriber contract.

23 Such term includes a qualified health plan under
24 title XXI of the Social Security Act, the public

1 health plan under title XXII of such Act, and the
2 medicare program under title XVIII of such Act.

3 (2) PLANS EXCLUDED.—Such term does not in-
4 clude—

5 (A) accident-only, credit, or disability in-
6 come insurance;

7 (B) coverage issued as a supplement to li-
8 ability insurance;

9 (C) an individual making payment on the
10 individual's own behalf (or on behalf of a rel-
11 ative or other individual) for deductibles, coin-
12 surance, or services not covered under a health
13 benefit plan; and

14 (D) such other plans as the Secretary may
15 determine, because of the limitation of benefits
16 to a single type or kind of health care, such as
17 dental services, or other reasons should not be
18 subject to the requirements of this section.

19 (3) PLANS INCLUDED.—Such term includes—

20 (A) worker's compensation or similar in-
21 surance, and

22 (B) automobile medical-payment insurance.

23 (4) TREATMENT OF DIRECT FEDERAL PROVI-
24 SION OF SERVICES.—Such term does not include a

1 Federal program that provides directly for the provi-
2 sion of health services to beneficiaries.

3 (b) HEALTH SERVICE PROVIDER.—In this subtitle,
4 the term “health service provider” includes a provider of
5 services (as defined in section 1861(u) of the Social Secu-
6 rity Act), physician, supplier, and other person furnishing
7 health care services.

8 (c) SECRETARY.—In this subtitle, the term “Sec-
9 retary” means Secretary of Health and Human Services.

10 **Subtitle C—Malpractice Reform**

11 **SEC. 331. MALPRACTICE REFORM.**

12 (a) STUDY BY PHYSICIAN PAYMENT REVIEW COM-
13 MISSION.—The Physician Payment Review Commission
14 shall conduct a study of—

15 (1) the need for reforms with respect to medical
16 malpractice liability claims, including the use of
17 practice guidelines developed by the Agency for
18 Health Care Policy and Research in such reforms,
19 and

20 (2) the impact of such reforms on—

21 (A) expenditures for health care services,

22 (B) access to such services,

23 (C) the quality of such services, and

24 (D) access of injured patients to the medi-
25 cal malpractice system.

1 (b) REPORT.—Not later than March 31, 1994, the
2 Commission shall submit a report to Congress on the
3 study conducted under subsection (a) and shall include in
4 the report such recommendations as the Commission con-
5 siders appropriate.

6 **TITLE IV—GROUP HEALTH**
7 **INSURANCE REFORM**

8 **SEC. 401. EXCISE TAX ON PREMIUMS RECEIVED ON**
9 **HEALTH INSURANCE POLICIES WHICH DO**
10 **NOT MEET CERTAIN REQUIREMENTS.**

11 (a) IN GENERAL.—Chapter 47 of the Internal Reve-
12 nue Code of 1986 (relating to taxes on group health
13 plans), as amended by section 101 of this Act, is further
14 amended by adding at the end thereof the following new
15 section:

16 **“SEC. 5000B. FAILURE TO SATISFY CERTAIN STANDARDS**
17 **FOR HEALTH INSURANCE.**

18 “(a) GENERAL RULE.—In the case of any person is-
19 suing applicable accident and health insurance contracts,
20 there is hereby imposed a tax on the failure of such person
21 to meet at any time during any taxable year the applicable
22 requirements of title XXIII of the Social Security Act. The
23 Secretary of Health and Human Services shall determine
24 whether any contract meets the requirements of such title.

25 “(b) AMOUNT OF TAX.—

1 “(1) IN GENERAL.—The amount of tax imposed
2 by subsection (a) by reason of 1 or more failures
3 during a taxable year shall be equal to 50 percent
4 of the gross premiums received during such taxable
5 year with respect to all accident and health insur-
6 ance contracts issued by the person on whom such
7 tax is imposed.

8 “(2) GROSS PREMIUMS.—For purposes of para-
9 graph (1), gross premiums shall include any consid-
10 eration received with respect to any accident and
11 health insurance contract.

12 “(c) LIMITATION ON TAX.—

13 “(1) TAX NOT TO APPLY WHERE FAILURE NOT
14 DISCOVERED EXERCISING REASONABLE DILI-
15 GENCE.—No tax shall be imposed by subsection (a)
16 with respect to any failure for which it is established
17 to the satisfaction of the Secretary that the person
18 on whom the tax is imposed did not know, and exer-
19 cising reasonable diligence would not have known,
20 that such failure existed.

21 “(2) TAX NOT TO APPLY WHERE FAILURES
22 CORRECTED WITHIN 30 DAYS.—No tax shall be im-
23 posed by subsection (a) with respect to any failure
24 if—

1 “(A) such failure was due to reasonable
2 cause and not to willful neglect, and

3 “(B) such failure is corrected during the
4 30-day period beginning on the 1st date any of
5 the persons on whom the tax is imposed knew,
6 or exercising reasonable diligence would have
7 known, that such failure existed.

8 “(3) WAIVER BY SECRETARY.—In the case of a
9 failure which is due to reasonable cause and not to
10 willful neglect, the Secretary may waive part or all
11 of the tax imposed by subsection (a).

12 “(d) LIABILITY FOR TAX.—The person issuing the
13 applicable accident and health contract with respect to
14 which a failure occurs shall be liable for the tax imposed
15 by subsection (a).

16 “(e) DEFINITIONS.—For purposes of this section—

17 “(1) IN GENERAL.—The term ‘applicable acci-
18 dent and health insurance contract’ means a con-
19 tract under which a person authorized under appli-
20 cable State insurance law provides a health insur-
21 ance plan or arrangement to any group consisting of
22 more than 2 individuals. Such term does not include
23 any self-insured plan of an employer and does not
24 include a qualified health maintenance organization

1 (as defined in section 1310(d) of the Public Health
2 Service Act).

3 “(2) CERTAIN CONTRACTS NOT COVERED.—The
4 term ‘applicable accident and health insurance con-
5 tract’ does not include any contract—

6 “(A) which provides for accident only, den-
7 tal only, or disability only coverage,

8 “(B) which provides coverage as a supple-
9 ment to liability insurance,

10 “(C) which provides insurance arising out
11 of a workmens’ compensation or similar law, or
12 automobile medical-payment insurance, or

13 “(D) which provides insurance which is re-
14 quired by law to be contained under any self-
15 insured plan of an employer.”.

16 (b) CLERICAL AMENDMENTS.—The table of sections
17 for such chapter 47 is amended by adding at the end
18 thereof the following new item:

“Sec. 5000B. Failure to satisfy certain standards for health in-
surance.”

19 **SEC. 402. GROUP HEALTH INSURANCE STANDARDS.**

20 The Social Security Act is amended by adding at the
21 end the following new title:

“(1) IN GENERAL.—No employment-related health plan may be issued on or after the effective date specified in subsection (d) (and no new contract may be offered under such plan with respect to any employer beginning on or after such effective date) unless the plan has been certified by the Secretary (in accordance with such procedures as the Secretary establishes) as meeting the applicable standards established under section 2302 by such effective date.

•HR 1398 IH

1 retary determines that such plan is in compliance
2 with such requirements.

3 “(b) SANCTIONS.—

4 “(1) TAX.—For application of excise tax in the
5 case of a nonconforming plan, see section 5000B of
6 the Internal Revenue Code of 1986.

7 “(2) NOTICE TO EMPLOYER IN THE CASE OF
8 INSURED PLANS.—If tax is imposed under section
9 5000B of the Internal Revenue Code of 1986, the
10 Secretary of the Treasury shall provide for notice to
11 be provided to each employer which meets the re-
12 quirement of section 2101 through coverage under
13 the plan of the imposition of the tax.

14 “(3) LOSS OF STATUS AS QUALIFIED EM-
15 PLOYER HEALTH PLAN.—

16 “(A) IN GENERAL.—If an employment-re-
17 lated health plan is determined to be in viola-
18 tion of subsection (a) and is not determined to
19 have come into compliance with the applicable
20 standards within 6 months after the date of the
21 initial determination of such a violation, the
22 plan shall no longer be treated as a qualified
23 employer health plan under title XXI as of the
24 end of such 6-month period.

1 “(B) NO ENFORCEMENT OF INSURANCE
2 CONTRACTS.—In the case of an employer that
3 is required, under part A of title XXI, to pro-
4 vide enrollment under a qualified employer
5 health plan and that meets such requirement
6 through an insured plan that is determined to
7 be in violation of subsection (a)—

8 “(i) if such plan is not brought into
9 compliance within 30 days after the date of
10 the violation, the employer may terminate
11 by notice the contract with the plan and is
12 not liable for payment of any additional
13 amounts under the plan, and

14 “(ii) if such plan no longer qualifies
15 as a qualified employer health plan, such
16 contract shall be terminated and the em-
17 ployer is not liable for payment of any
18 amounts for periods in which the plan no
19 longer qualifies as a qualified employer
20 health plan.

21 “(d) EFFECTIVE DATE.—The effective date specified
22 in this subsection is January 1, 1994.

23 **“SEC. 2302. ESTABLISHMENT OF STANDARDS.**

24 “(a) ESTABLISHMENT OF STANDARDS.—The Sec-
25 retary shall develop and publish, by not later than October

1 1, 1993, specific standards to implement the requirements
2 of this title and to be applied under section 5000B of the
3 Internal Revenue Code of 1986.

4 “(b) TELEPHONE INFORMATION SYSTEM.—The Sec-
5 retary shall provide for the establishment of a toll-free
6 telephone information and complaint system which
7 provides for—

8 “(1) a system for the receipt and disposition of
9 consumer complaints or inquiries regarding compli-
10 ance of health plans with the requirements of this
11 title, and

12 “(2) information to small employers about car-
13 riers that offer small employer health plans in the
14 area covered by the regulatory authority.

15 Such system shall provide for the recording of consumer
16 complaints in accordance with a uniform methodology rec-
17 ognized by the Secretary.

18 “(c) APPLICATION TO ERISA.—The Secretary shall
19 consult with the Secretary of Labor concerning the appli-
20 cation of the requirements of this part to employee welfare
21 benefit plans under title I of the Employee Retirement In-
22 come Security Act of 1974.

1 **“SEC. 2303. REQUIREMENTS APPLICABLE TO ALL EMPLOY-**
2 **MENT-RELATED HEALTH PLANS.**

3 “(a) NO DISCRIMINATION BASED ON HEALTH STA-
4 TUS FOR CERTAIN SERVICES.—Except as provided under
5 subsection (b), an employment-related health plan may not
6 deny, limit, or condition the coverage under (or benefits
7 of) the plan with respect to required health services based
8 on the health status, claims experience, receipt of health
9 care, medical history, or lack of evidence of insurability,
10 of an individual.

11 “(b) TREATMENT OF PRE-EXISTING CONDITION EX-
12 CLUSIONS FOR ALL SERVICES.—The provisions of section
13 2154(b) (relating to treatment of pre-existing condition
14 exclusion) shall apply to employer-related health plans
15 under this section in the same manner as they apply to
16 qualified health plans under that section.

17 **“SEC. 2304. DEFINITIONS.**

18 “(a) HEALTH PLAN AND OTHER DEFINITIONS RE-
19 LATING TO HEALTH PLANS.—In this title:

20 “(1) HEALTH PLAN.—

21 “(A) IN GENERAL.—The term ‘health plan’
22 means—

23 “(i) a group health plan (as defined in
24 section 605 of the Employee Retirement
25 Income Security Act of 1974), and

1 “(ii) any other health insurance ar-
2 rangement, including any arrangement
3 (other than a group health plan) consisting
4 of a hospital or medical expense incurred
5 policy or certificate, hospital or medical
6 service plan contract, health maintenance
7 organization subscriber contract;

8 but does not include a qualified health mainte-
9 nance organization (as defined in section
10 1310(d) of the Public Health Service Act).

11 “(B) EXCLUSIONS.—

12 “(i) CERTAIN TYPES OF INSUR-
13 ANCE.—Such term does not include—

14 “(I) accident-only, credit, or dis-
15 ability income insurance,

16 “(II) coverage issued as a supple-
17 ment to liability insurance,

18 “(III) worker’s compensation or
19 similar insurance, or

20 “(IV) automobile medical-pay-
21 ment insurance.

22 “(ii) PUBLIC HEALTH PLAN.—Such
23 term does not include the public health
24 plan under title XXII.

1 “(2) EMPLOYMENT-RELATED HEALTH PLAN.—

2 The term ‘employment-related health plan’ means
3 any employee welfare benefit plan (as defined in sec-
4 tion 3(1) of the Employee Retirement Income Secu-
5 rity Act of 1974) that is a health plan.

6 “(3) INSURED EMPLOYMENT-RELATED HEALTH

7 PLAN.—The term ‘insured employment-related
8 health plan’ means an employment-related health
9 plan that has been provided by a person authorized
10 under applicable State insurance law, and does not
11 include any self-insured employment-related health
12 plan.

13 “(4) SELF-INSURED EMPLOYMENT-RELATED

14 HEALTH PLAN.—The term ‘self-insured employment-
15 related health plan’ means an employment-related
16 health plan in which the employer or employment-re-
17 lated group assumes the underwriting risk for the
18 plan (whether or not there is any reinsurance or
19 similar mechanism to underwrite a portion of that
20 risk).

21 “(5) SMALL EMPLOYER HEALTH PLAN.—The

22 term ‘small employer health plan’ means an employ-
23 ment-related health plan insofar as it offers benefits
24 with respect to any small employer, as defined in

1 subsection (c)(4), or the employees of a small em-
2 ployer.

3 “(b) CARRIER; HEALTH MAINTENANCE ORGANIZA-
4 TION; AND OTHER DEFINITIONS RELATING TO CAR-
5 RRIERS.—In this part:

6 “(1) CARRIER.—The term ‘carrier’ means any
7 person that offers a health plan, whether through in-
8 surance or otherwise, including a licensed insurance
9 company, a prepaid hospital or medical service plan,
10 a health maintenance organization, a self-insurer
11 carrier, and a multiple employer welfare arrange-
12 ment.

13 “(2) HEALTH MAINTENANCE ORGANIZATION.—
14 The term ‘health maintenance organization’ has the
15 meaning given the term ‘eligible organization’ in sec-
16 tion 1876(b).

17 “(3) SELF-INSURER CARRIER.—The term ‘self-
18 insurer carrier’ means a carrier that is not a li-
19 censed insurance company, a prepaid hospital or
20 medical service plan, or a health maintenance orga-
21 nization, that offers a health plan directly with re-
22 spect to an employment-related group.

23 “(4) SMALL EMPLOYER CARRIER.—The term
24 ‘small employer carrier’ means any carrier which of-
25 fers small employer health plans.

1 “(c) GENERAL DEFINITIONS.—In this part:

2 “(1) COMMUNITY.—The term ‘community’ has
3 the meaning given such term in section 2131(e).

4 “(2) FULL-TIME EMPLOYEE.—The term ‘full-
5 time employee’ has the meaning given such term in
6 section 2181(b)(1).

7 “(3) REFERENCE PREMIUM RATE.—The term
8 ‘reference premium rate’ means, for a rating period
9 in a community, the lowest premium rate charged or
10 which could have been charged by the small em-
11 ployer carrier to small employers under a rating sys-
12 tem in the community for health plans with the
13 same or similar coverage. The reference premium
14 rate is determined without regard to any adjustment
15 for age or sex described in section 2312(c).

16 “(4) SMALL EMPLOYER.—The term ‘small em-
17 ployer’ has the meaning given such term in section
18 2181(c)(1) and also includes a medium-size em-
19 ployer (as defined in section 2181(c)(2)).

20 “(5) STATE.—The term ‘State’ means the 50
21 States and the District of Columbia.

22 **“SEC. 2305. NOTICE OF PLANS MEETINGS REQUIREMENTS.**

23 “The Secretary of Health and Human Services shall
24 publish periodically the names and issuers of insured em-
25 ployment-related small employer health plans that have

1 been found to meet the applicable requirements of this
2 title.

3 “PART 2—SMALL EMPLOYER HEALTH INSURANCE

4 REFORM

5 “SEC. 2311. ENROLLMENT PRACTICE AND GUARANTEED RE-

6 NEWABILITY REQUIREMENTS FOR SMALL EM-

7 PLOYER HEALTH PLANS.

8 “(a) REGISTRATION.—

9 “(1) IN GENERAL.—Each small employer car-
10 rier (as defined in section 2304(b)(5)) shall register
11 with the Secretary.

12 “(2) NO PREEMPTION OF STATE INFORMATION
13 REQUIREMENTS.—Nothing in paragraph (1) shall be
14 construed as preventing the applicable regulatory
15 authority in a State from requiring, in the case of
16 carriers that are not self-insurance carriers, such ad-
17 ditional information in conjunction with, or apart
18 from, the registration required under paragraph (1)
19 as the applicable regulatory authority may be au-
20 thorized to require under State law.

21 “(b) GUARANTEED ISSUE.—

22 “(1) IN GENERAL.—Subject to the succeeding
23 provisions of this subsection, a carrier that offers a
24 health plan to small employers located in a commu-
25 nity must offer the same plan to any other small

1 employer located in the community. Such require-
2 ment shall apply on a continuous, year-round basis.

3 “(2) TREATMENT OF HEALTH MAINTENANCE
4 ORGANIZATIONS.—

5 “(A) GEOGRAPHIC LIMITATIONS.—A
6 health maintenance organization may deny en-
7 rollment to employees (and family members) of
8 a small employer if the employees are located
9 outside the service area of the organization, but
10 only if such denial is applied uniformly without
11 regard to health status or insurability.

12 “(B) SIZE LIMITS.—A health maintenance
13 organization may apply to the Secretary to
14 cease enrolling new small employer groups in its
15 small employer health plan (or in a geographic
16 area served by the plan) if—

17 “(i) it ceases to enroll any new em-
18 ployer groups, and

19 “(ii) it can demonstrate that its finan-
20 cial or administrative capacity to serve pre-
21 viously enrolled groups and individuals
22 (and additional individuals who will be ex-
23 pected to enroll because of affiliation with
24 such previously enrolled groups) will be im-

1 paired if it is required to enroll new em-
2 ployer groups.

3 “(3) GROUNDS FOR REFUSAL TO ISSUE OR
4 RENEW.—A carrier may refuse to issue or renew or
5 terminate a plan only for—

6 “(A) nonpayment of premiums, and

7 “(B) fraud or misrepresentation.

8 “(c) MINIMUM PLAN PERIOD.—A carrier may not
9 offer to, or issue with respect to, a small employer a small
10 employer health plan with a term of less than 12 months.

11 “(d) NOTICES AND RENEWAL PERIODS.—

12 “(1) NOTICE AND SPECIFICATION OF RATES
13 AND ADMINISTRATIVE CHANGES.—

14 “(A) NOTICE.—The small employer carrier
15 of a small employer health plan shall provide
16 for notice, at least 30 days before the date of
17 expiration of the health plan, of the terms for
18 renewal of the plan. Except with respect to
19 rates and administrative changes, the terms of
20 renewal (including benefits) shall be the same
21 as the terms of issuance.

22 “(B) RENEWAL RATES SAME AS ISSUANCE
23 RATES.—The carrier may change the terms for
24 such renewal, but the premium rates charged

1 with respect to such renewal shall be the same
2 as that for a new issue.

3 “(2) PERIOD OF RENEWAL.—The period of re-
4 newal of each small employer health plan shall be for
5 a period of not less than 12 months.

6 **“SEC. 2312. RATING PRACTICES FOR SMALL EMPLOYER**
7 **HEALTH PLANS.**

8 “(a) COHESIVE RATING SYSTEM AND ACTUARIAL
9 CERTIFICATION.—

10 “(1) IN GENERAL.—The premiums (including
11 reference premium rate, as defined in section
12 2304(c)(3)) and age-sex adjustments under sub-
13 section (c) for all small employer health plans of the
14 same entity shall—

15 “(A) be established based on a single cohe-
16 sive rating system which is applied consistently
17 for all employer groups and is designed not to
18 treat groups, after January 1, 1994, differently
19 based on health status or risk status; and

20 “(B) be actuarially certified annually.

21 “(2) ACTUARIAL CERTIFIED DEFINED.—For
22 purposes of paragraph (1)(B), a plan is considered
23 to be ‘actuarially certified’ if there is a written state-
24 ment, by a member of the American Academy of Ac-
25 tuaries or other individual acceptable to the Sec-

1 retary that a small employer carrier is in compliance
2 with this section, based upon the individual's exam-
3 ination, including a review of the appropriate records
4 and of the actuarial assumptions and methods uti-
5 lized by the carrier in establishing premium rates for
6 applicable health plans.

7 “(b) USE OF COMMUNITY-RATED REFERENCE PRE-
8 MIUM RATES.—The reference premium rate charged for
9 a small employer health plan with similar benefits in a
10 community for a type of family enrollment (described in
11 subsection (d)) shall be the same for all small employers.

12 “(c) AGE AND SEX ADJUSTMENT TO COMMUNITY-
13 RATING.—

14 “(1) IN GENERAL.—Subject to paragraph (2), a
15 small employer health plan may provide for an ad-
16 justment to the reference premium rate based on
17 age and gender of covered individuals. Any such ad-
18 justment shall be applied consistently to all small
19 employers.

20 “(2) LIMITATION ON ADJUSTMENT.—The ad-
21 justment under paragraph (1) may not result, with
22 respect to small employer health plans with similar
23 benefits in a community, in a premium rate for the
24 most expensive age-sex group exceeding 133 percent

1 of the premium rate for the least expensive age-sex
2 group.

3 “(d) TYPES OF FAMILY ENROLLMENT.—

4 “(1) IN GENERAL.—Each small employer health
5 plan shall permit enrollment of (and shall compute
6 premiums separately for) individuals based on each
7 of the following beneficiary classes:

8 “(A) 1 adult.

9 “(B) A married couple without children.

10 “(C) A married couple with 1 or more chil-
11 dren, or 1 adult with 1 or more children.

12 “(2) APPLICATION OF DEFINITIONS.—The defi-
13 nitions in section 2282 shall apply for purposes of
14 this subsection.

15 **“SEC. 2313. BASIC BENEFIT PACKAGE FOR SMALL EM-**
16 **PLOYER HEALTH PLANS.**

17 “(a) BENEFITS AND COST-SHARING IN QUALIFIED
18 EMPLOYER HEALTH PLANS.—Except as provided in sub-
19 section (b), no small employer health plan may be issued
20 to a small employer by a carrier unless—

21 “(1) the plan provides for benefits for all re-
22 quired health services (as defined in section
23 2211(a)(2));

24 “(2) the plan does not impose cost-sharing with
25 respect to required health services in excess of the

1 deductibles and coinsurance permitted under title
 2 XXII with respect to such services (not taking into
 3 account any low-income assistance under part E of
 4 such title); and

5 “(3) the carrier makes available to the employer
 6 a small employer health plan that, subject to sub-
 7 section (b), only provides the benefits for required
 8 health services and the maximum cost-sharing con-
 9 sistent with paragraphs (1) and (2).

10 “(b) EXCEPTIONS FOR HMO’S.—Subsection (a)(3)
 11 shall not apply to the plan of a health maintenance organi-
 12 zation.

13 **“SEC. 2314. MISCELLANEOUS DISCLOSURE AND RECORD-**
 14 **KEEPING REQUIREMENTS FOR SMALL EM-**
 15 **PLOYER HEALTH PLANS.**

16 “(a) DISCLOSURE TO EMPLOYERS.—

17 “(1) GENERAL DISCLOSURE.—Each small em-
 18 ployer carrier shall disclose to each small employer
 19 before issuing a small employer health plan the fol-
 20 lowing:

21 “(A) The availability (pursuant to the re-
 22 quirement of section 2313(a)(3) of a plan in-
 23 cluding only basic benefits.

1 “(B) The limits, imposed under section
2 2312, on the premiums permitted to be charged
3 for such plans.

4 “(C) The rights of guaranteed issue pro-
5 vided under section 2311.

6 Such disclosure shall be in addition to any disclosure
7 required generally of qualified health plans under
8 section 2158(a).

9 “(2) STANDARD FORMAT.—The disclosure
10 under paragraph (1) shall be made in a uniform for-
11 mat established by the Secretary.

12 “(b) INFORMATION FILED.—

13 “(1) IN GENERAL.—Each small employer car-
14 rier shall disclose to the Secretary, in a manner
15 specified by the Secretary, information concerning
16 applicable premiums for small employer health
17 plans.

18 “(2) ADDITIONAL INFORMATION.—Nothing in
19 this subsection shall be construed as limiting the in-
20 formation which a State may require to be reported
21 by small employer carriers (other than self-insured
22 carriers).

23 **“SEC. 2315. PAYMENT OF COMMISSIONS.**

24 “A small employer carrier may not vary the remu-
25 neration paid a broker for the sale or renewal of any small

1 employer health plan based, directly or indirectly, on the
 2 claims experience associated with the group to which the
 3 plan was sold.

4 **“SEC. 2316. NONAPPLICATION IN PUERTO RICO AND THE**
 5 **TERRITORIES.**

6 “This part shall not apply outside the 50 States or
 7 the District of Columbia.”.

8 **TITLE V—CHANGES IN**
 9 **MEDICARE PROGRAM**

10 **SEC. 501. COVERAGE OF COLORECTAL SCREENING.**

11 (a) IN GENERAL.—Section 1834 of the Social Secu-
 12 rity Act (42 U.S.C. 1395m), as amended by section
 13 4163(b)(2) of the Omnibus Budget Reconciliation Act of
 14 1990 (in this title referred to as “OBRA-1990”), is
 15 amended by inserting after subsection (c) the following
 16 new subsection:

17 “(d) FREQUENCY AND PAYMENT LIMITS FOR
 18 SCREENING FECAL-OCCULT BLOOD TESTS AND SCREEN-
 19 ING FLEXIBLE SIGMOIDOSCOPIES.—

20 “(1) SCREENING FECAL-OCCULT BLOOD
 21 TESTS.—

22 “(A) PAYMENT LIMIT.—In establishing fee
 23 schedules under section 1833(h) with respect to
 24 screening fecal-occult blood tests provided for
 25 the purpose of early detection of colon cancer,

1 except as provided by the Secretary under para-
2 graph (3)(A), the payment amount established
3 for tests performed—

4 “(i) in 1994 shall not exceed \$5; and

5 “(ii) in a subsequent year, shall not
6 exceed the limit on the payment amount
7 established under this subsection for such
8 tests for the preceding year, adjusted by
9 the applicable adjustment under section
10 1833(h) for tests performed in such year.

11 “(B) FREQUENCY LIMIT.—Subject to revi-
12 sion by the Secretary under paragraph (3)(B),
13 no payment may be made under this part for
14 a screening fecal-occult blood test provided to
15 an individual for the purpose of early detection
16 of colon cancer—

17 “(i) if the individual is under 50 years
18 of age; or

19 “(ii) if the test is performed within
20 the 11 months after a previous screening
21 fecal-occult blood test.

22 “(2) SCREENING FLEXIBLE SIGMOIDOS-
23 COPIES.—

24 “(A) PAYMENT AMOUNT.—The Secretary
25 shall establish a payment amount under section

1 1848 with respect to screening flexible
2 sigmoidoscopies provided for the purpose of
3 early detection of colon cancer that is consistent
4 with payment amounts under such section for
5 similar or related services, except that such
6 payment amount shall be established without
7 regard to subsection (a)(2)(A) of such section.

8 “(B) FREQUENCY LIMIT.—Subject to revi-
9 sion by the Secretary under paragraph (3)(B),
10 no payment may be made under this part for
11 a screening flexible sigmoidoscopy provided to
12 an individual for the purpose of early detection
13 of colon cancer—

14 “(i) if the individual is under 50 years
15 of age; or

16 “(ii) if the procedure is performed
17 within the 59 months after a previous
18 screening flexible sigmoidoscopy.

19 “(3) REDUCTIONS IN PAYMENT LIMIT AND RE-
20 VISION OF FREQUENCY.—

21 “(A) REDUCTIONS IN PAYMENT LIMIT.—

22 The Secretary shall review from time to time
23 the appropriateness of the amount of the pay-
24 ment limit established for screening fecal-occult
25 blood tests under paragraph (1)(A). The Sec-

1 retary may, with respect to tests performed in
2 a year after 1996, reduce the amount of such
3 limit as it applies nationally or in any area to
4 the amount that the Secretary estimates is re-
5 quired to assure that such tests of an appro-
6 priate quality are readily and conveniently
7 available during the year.

8 “(B) REVISION OF FREQUENCY.—

9 “(i) REVIEW.—The Secretary, in con-
10 sultation with the Director of the National
11 Cancer Institute, shall review periodically
12 the appropriate frequency for performing
13 screening fecal-occult blood tests and
14 screening flexible sigmoidoscopies based on
15 age and such other factors as the Sec-
16 retary believes to be pertinent.

17 “(ii) REVISION OF FREQUENCY.—The
18 Secretary, taking into consideration the re-
19 view made under clause (i), may revise
20 from time to time the frequency with
21 which such tests and procedures may be
22 paid for under this subsection, but no such
23 revision shall apply to tests or procedures
24 performed before January 1, 1997.

1 “(4) LIMITING CHARGES OF NONPARTICIPATING
2 PHYSICIANS.—

3 “(A) IN GENERAL.—In the case of a
4 screening flexible sigmoidoscopy provided to an
5 individual for the purpose of early detection of
6 colon cancer for which payment may be made
7 under this part, if a nonparticipating physician
8 provides the procedure to an individual enrolled
9 under this part, the physician may not charge
10 the individual more than the limiting charge (as
11 defined in subparagraph (B), or, if less, as de-
12 fined in section 1848(g)(2)).

13 “(B) LIMITING CHARGE DEFINED.—In
14 subparagraph (A), the term ‘limiting charge’
15 means, 115 percent of the payment limit estab-
16 lished under paragraph (2)(A).

17 “(C) ENFORCEMENT.—If a physician or
18 supplier knowingly and willfully imposes a
19 charge in violation of subparagraph (A), the
20 Secretary may apply sanctions against such
21 physician or supplier in accordance with section
22 1842(j)(2).”.

23 (b) CONFORMING AMENDMENTS.—(1) Paragraphs
24 (1)(D) and (2)(D) of section 1833(a) of such Act (42
25 U.S.C. 1395l(a)) are each amended by striking “sub-

1 section (h)(1),” and inserting “subsection (h)(1) or section
2 1834(d)(1),”.

3 (2) Section 1833(h)(1)(A) of such Act (42 U.S.C.
4 1395l(h)(1)(A)) is amended by striking “The Secretary”
5 and inserting “Subject to paragraphs (1) and (3)(A) of
6 section 1834(d), the Secretary”.

7 (3) Clauses (i) and (ii) of section 1848(a)(2)(A) of
8 such Act (42 U.S.C. 1395w-4(a)(2)(A)) are each amended
9 by striking “a service” and inserting “a service (other
10 than a screening flexible sigmoidoscopy provided to an
11 individual for the purpose of early detection of colon
12 cancer)”.

13 (4) Section 1862(a) of such Act (42 U.S.C. 1395y(a))
14 is amended—

15 (A) in paragraph (1)—

16 (i) in subparagraph (E), by striking “and”
17 at the end,

18 (ii) in subparagraph (F), by striking the
19 semicolon at the end and inserting “, and”, and

20 (iii) by adding at the end the following new
21 subparagraph:

22 “(G) in the case of screening fecal-occult blood
23 tests and screening flexible sigmoidoscopies provided
24 for the purpose of early detection of colon cancer,

1 which are performed more frequently than is covered
2 under section 1834(d);” and

3 (B) in paragraph (7), by striking “paragraph
4 (1)(B) or under paragraph (1)(F)” and inserting
5 “subparagraphs (B), (F), or (G) of paragraph (1)”.

6 (c) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to screening fecal-occult blood tests
8 and screening flexible sigmoidoscopies performed on or
9 after January 1, 1994.

10 **SEC. 502. COVERAGE OF CERTAIN IMMUNIZATIONS.**

11 (a) IN GENERAL.—Section 1861(s)(10) of the Social
12 Security Act (42 U.S.C. 1395x(s)(10)) is amended—

13 (1) in subparagraph (A)—

14 (A) by striking “, subject to section
15 4071(b) of the Omnibus Budget Reconciliation
16 Act of 1987,” and

17 (B) by striking “; and” and inserting a
18 comma;

19 (2) in subparagraph (B), by striking the semi-
20 colon at the end and inserting “, and”; and

21 (3) by adding at the end the following new sub-
22 paragraph:

23 “(C) tetanus-diphtheria booster and its admin-
24 istration;”.

1 (b) LIMITATION ON FREQUENCY.—Section
2 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), as
3 amended by section 502(b)(4)(A), is amended—

4 (1) in subparagraph (F), by striking “and” at
5 the end;

6 (2) in subparagraph (G), by striking the semi-
7 colon at the end and inserting “, and”; and

8 (3) by adding at the end the following new sub-
9 paragraph:

10 “(H) in the case of an influenza vaccine, which
11 is administered within the 11 months after a pre-
12 vious influenza vaccine, and, in the case of a tetanus-diphtheria booster, which is administered within
13 the 119 months after a previous tetanus-diphtheria
14 booster;”.

16 (c) CONFORMING AMENDMENT.—Section 1862(a)(7)
17 of such Act (42 U.S.C. 1395y(a)(7)), as amended by sec-
18 tion 502(b)(4)(B), is amended by striking “or (G)” and
19 inserting “(G), or (H)”.

20 (d) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to influenza vaccines and tetanus-
22 diphtheria boosters administered on or after January 1,
23 1994.

1 **SEC. 503. COVERAGE OF WELL-CHILD CARE.**

2 (a) IN GENERAL.—Section 1861(s)(2) of the Social
3 Security Act (42 U.S.C. 1395x(s)(2)), as amended by sec-
4 tion 4201(d)(1) of OBRA–1990, is amended—

5 (1) by striking “and” at the end of subpara-
6 graph (O);

7 (2) by striking the semicolon at the end of sub-
8 paragraph (P) and inserting “; and”; and

9 (3) by adding at the end the following new sub-
10 paragraph:

11 “(Q) well-child services (as defined in sub-
12 section (ll)(1)) provided to an individual entitled to
13 benefits under this title who is under 19 years of
14 age;”.

15 (b) SERVICES DEFINED.—Section 1861 of such Act
16 (42 U.S.C. 1395x) is amended—

17 (1) by redesignating the subsection (jj) added
18 by section 4163(a)(2) of OBRA–1990 as subsection
19 (kk); and

20 (2) by inserting after subsection (kk) (as so re-
21 designated) the following new subsection:

22 “well-child services

23 “(ll)(1) The term ‘well-child services’ means well-
24 child care, including routine office visits, routine immuni-
25 zations (including the vaccine itself), routine laboratory
26 tests, and preventive dental care, provided in accordance

1 with the periodicity schedule established with respect to
2 the services under paragraph (2).

3 “(2) The Secretary, in consultation with the Amer-
4 ican Academy of Pediatrics, the Advisory Committee on
5 Immunization Practices, and other entities considered ap-
6 propriate by the Secretary, shall establish a schedule of
7 periodicity which reflects the appropriate frequency with
8 which the services referred to in paragraph (1) should be
9 provided to healthy children.”.

10 (c) CONFORMING AMENDMENTS.—(1) Section
11 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), as
12 amended by sections 502(b)(4)(A) and 503(b), is amend-
13 ed—

14 (A) in subparagraph (G), by striking “and” at
15 the end;

16 (B) in subparagraph (H), by striking the semi-
17 colon at the end and inserting “, and”; and

18 (C) by adding at the end the following new sub-
19 paragraph:

20 “(I) in the case of well-child services, which are
21 provided more frequently than is provided under the
22 schedule of periodicity established by the Secretary
23 under section 1861(ll)(2) for such services;”.

24 (2) Section 1862(a)(7) of such Act (42 U.S.C.
25 1395y(a)(7)), as amended by sections 502(b)(4)(B) and

1 503(c), is amended by striking “or (H)” and inserting
2 “(H), or (I)”.

3 (d) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to well-child services provided on
5 or after January 1, 1994.

6 **SEC. 504. ANNUAL SCREENING MAMMOGRAPHY.**

7 (a) ANNUAL SCREENING MAMMOGRAPHY FOR
8 WOMEN OVER AGE 64.—Section 1834(c)(2)(A) of the So-
9 cial Security Act (42 U.S.C. 1395m(b)(2)(A)), as added
10 by section 4163(b)(2) of OBRA–1990, is amended—

11 (1) in clause (iv), by striking “but under 65
12 years of age,”; and

13 (2) by striking clause (v).

14 (b) EFFECTIVE DATE.—The amendments made by
15 subsection (a) shall apply to screening mammography per-
16 formed on or after January 1, 1994.

17 **SEC. 505. DEMONSTRATION PROJECTS FOR COVERAGE OF**
18 **OTHER PREVENTIVE SERVICES.**

19 (a) ESTABLISHMENT.—The Secretary of Health and
20 Human Services (in this title referred to as the “Sec-
21 retary”) shall establish and provide for the conduct of a
22 series of ongoing demonstration projects under which the
23 Secretary shall provide for coverage of the preventive serv-
24 ices described in subsection (c) under the medicare pro-
25 gram in order to determine—

1 (1) the feasibility and desirability of expanding
2 coverage of medical and other health services under
3 the medicare program to include coverage of such
4 services for all individuals enrolled under part B of
5 title XVIII of the Social Security Act; and

6 (2) appropriate methods for the delivery of
7 those services to medicare beneficiaries.

8 (b) SITES FOR PROJECT.—The Secretary shall pro-
9 vide for the conduct of the demonstration projects estab-
10 lished under subsection (a) at the sites at which the Sec-
11 retary conducts the demonstration program established
12 under section 9314 of the Consolidated Omnibus Budget
13 Reconciliation Act of 1985 and at such other sites as the
14 Secretary considers appropriate.

15 (c) SERVICES COVERED UNDER PROJECTS.—The
16 Secretary shall cover the following services under the se-
17 ries of demonstration projects established under
18 subsection (a):

19 (1) Glaucoma screening.

20 (2) Cholesterol screening and cholesterol-reduc-
21 ing drug therapies.

22 (3) Screening and treatment for osteoporosis,
23 including tests for bone-marrow density and hor-
24 mone replacement therapy.

1 (4) Screening services for pregnant women, in-
2 cluding ultra-sound and clamydial testing and ma-
3 ternal serum alfa-protein.

4 (5) One-time comprehensive assessment for in-
5 dividuals beginning at age 65 or 75.

6 (6) Other services considered appropriate by the
7 Secretary.

8 (d) REPORTS TO CONGRESS.—Not later than October
9 1, 1995, and every 2 years thereafter, the Secretary shall
10 submit a report to the Committee on Finance of the Sen-
11 ate and the Committee on Ways and Means and the Com-
12 mittee on Energy and Commerce of the House of Rep-
13 resentatives describing findings made under the dem-
14 onstration projects conducted pursuant to subsection (a)
15 during the preceding 2-year period and the Secretary's
16 plans for the demonstration projects during the succeeding
17 2-year period.

18 (e) AUTHORIZATION OF APPROPRIATIONS.—There
19 are authorized to be appropriated from the Federal Sup-
20 plementary Medical Insurance Trust Fund for expenses
21 incurred in carrying out the series of demonstration
22 projects established under subsection (a) the following
23 amounts:

24 (1) \$4,000,000 for fiscal year 1994.

25 (2) \$4,000,000 for fiscal year 1995.

1 (3) \$5,000,000 for fiscal year 1996.

2 (4) \$5,000,000 for fiscal year 1997.

3 (5) \$6,000,000 for fiscal year 1998.

4 **SEC. 506. OTA STUDY OF PROCESS FOR REVIEW OF MEDI-**
5 **CARE COVERAGE OF PREVENTIVE SERVICES.**

6 (a) STUDY.—The Director of the Office of Tech-
7 nology Assessment (in this section referred to as the “Di-
8 rector”) shall, subject to the approval of the Technology
9 Assessment Board, conduct a study to develop a process
10 for the regular review for the consideration of coverage
11 of preventive services under the medicare program, and
12 shall include in such study a consideration of different
13 types of evaluations, the use of demonstration projects to
14 obtain data and experience, and the types of measures,
15 outcomes, and criteria that should be used in making cov-
16 erage decisions.

17 (b) REPORT.—Not later than 2 years after the date
18 of the enactment of this Act, the Director shall submit
19 a report to the Committee on Finance of the Senate and
20 the Committee on Ways and Means and the Committee
21 on Energy and Commerce of the House of Representatives
22 on the study conducted under subsection (a).

1 **SEC. 507. PHASED-IN REQUIREMENT OF PART B ENROLL-**
2 **MENT.**

3 (a) IN GENERAL.—Section 1811 of the Social Secu-
4 rity Act (42 U.S.C. 1395c) is amended by inserting “(a)”
5 after “1811.” and by adding at the end the following new
6 subsection:

7 “(b) Notwithstanding sections 226 and 226A and any
8 other provision of this title, effective for services furnished
9 on or after January 1, 1997, payment may not be made
10 under this part for items and services during any period
11 in which the individual is not enrolled under part B or
12 under a qualified employer health plan (as defined in sec-
13 tion 2121(a)). For purposes of the previous sentence, enti-
14 tlement to benefits under this part (but for this sub-
15 section) shall not be considered enrollment in a qualified
16 health plan.”.

17 (b) CLARIFICATION OF COVERAGE PERIOD.—Section
18 1838(b) of such Act (42 U.S.C. 1395q(b)) is amended to
19 read as follows:

20 “(b)(1) An individual’s coverage period shall continue
21 until the individual’s enrollment is terminated by the filing
22 of notice that the individual—

23 “(A) no longer wishes to participate in the in-
24 surance program established by this part,

25 “(B) is covered under a qualified health plan,
26 and

1 “(C) has notified the plan that the individual is
2 entitled to benefits under part A of this title.

3 “(2) The termination of coverage under paragraph
4 (1) shall take effect at the close of the month following
5 the month in which the notice is filed.

6 “(3) Such termination shall no longer be effective at
7 such time as the individual is eligible to be enrolled under
8 this part and is no longer covered under a qualified health
9 plan.”.

10 (c) ELIMINATION OF LATE ENROLLMENT PEN-
11 ALTIES.—

12 (1) IN GENERAL.—Section 1839 of such Act
13 (42 U.S.C. 1395r) is amended by striking subsection
14 (b).

15 (2) CONFORMING AMENDMENTS.—(A) Section
16 1839(a)(2) of such Act (42 U.S.C. 1395r(a)(2)) is
17 amended—

18 (i) in subsection (a)(2), by striking “sub-
19 sections (b) and (e)” and inserting “subsection
20 (e)”, and

21 (ii) by striking subsection (d).

22 (B) Section 1843(d)(1) of such Act (42 U.S.C.
23 1395v(d)(1)) is amended by striking “(without any
24 increase under subsection (b) thereof)”.

1 (d) EFFECTIVE DATE.—The amendments made by
2 subsections (b) and (c) shall take effect January 1, 1997,
3 and shall apply to premiums beginning with such January.

4 **SEC. 508. CHANGES IN PARTICIPATION AGREEMENTS.**

5 (a) PROVIDERS OF SERVICES.—Section 1866(a)(1)
6 of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is
7 amended—

8 (1) by striking “and” at the end of subpara-
9 graph (P),

10 (2) by striking the period at the end of sub-
11 paragraph (Q) and inserting “, and”, and

12 (3) by inserting after subparagraph (Q) the fol-
13 lowing new subparagraph:

14 “(R) effective January 1, 1994, to have
15 entered into a participation agreement under
16 title XXII of this Act and to report to the Fed-
17 eral Health Care Cost Containment Commission
18 information, described in section 302(d)(2) of
19 the Health Insurance Coverage and Cost Con-
20 tainment Act of 1993, in accordance with uni-
21 form standards developed under such section.”.

22 (b) PHYSICIANS.—Section 1842(h)(1) of such Act
23 (42 U.S.C. 1395u(h)(1)) is amended by adding at the end
24 the following: “No such agreement with a physician shall
25 be entered into and continued in effect on or after January

1 1, 1994, unless the physician has entered into a com-
 2 parable agreement for purposes of title XXII and agrees
 3 to report to the Federal Health Care Cost Containment
 4 Commission information, described in section 302(d)(2) of
 5 the Health Insurance Coverage and Cost Containment Act
 6 of 1993, in accordance with uniform standards developed
 7 under such section.”

8 **SEC. 509. ASSURING COORDINATION OF ENROLLMENT**
 9 **WITH QUALIFIED HEALTH PLANS.**

10 (a) NOTICES.—Section 1837 of the Social Security
 11 Act (42 U.S.C. 1395p) is amended by adding at the end
 12 the following new subsection:

13 “(j) The Secretary shall provide for notices of cov-
 14 erage under this part (and part A) in the same manner
 15 as qualified health plans are required to provide notices
 16 of coverage under section 2157(b).”.

17 (b) TREATMENT OF SECONDARY PAYMENT IN
 18 CASE OF PART-TIME EMPLOYMENT.—Section
 19 1862(b)(1)(A)(i)(I) of such Act (42 U.S.C.
 20 1395y(b)(1)(A)(i)(I)) is amended by inserting “other than
 21 on a part-time described in section 2181(b)(2)” after “in-
 22 dividual’s spouse)”.

23 (c) EFFECTIVE DATES.—(1) The amendment made
 24 by subsection (a) shall take effect on the date specified
 25 in section 2157(b)(2) of the Social Security Act.

1 (2) The amendment made by subsection (b) shall
2 apply to employment occurring on or after January 1,
3 1994.

4 **TITLE VI—FINANCING** 5 **PROVISIONS**

6 **Subtitle A—General Provisions**

7 **SEC. 601. INCREASE IN WAGE BASE FOR HOSPITAL INSUR-** 8 **ANCE TAX.**

9 (a) GENERAL RULE.—Paragraph (2) of section
10 3121(x) of the Internal Revenue Code of 1986 (defining
11 applicable contribution base for hospital insurance tax) is
12 amended—

13 (1) in subparagraph (A), by striking “and” at
14 the end,

15 (2) in subparagraph (B), by striking “for any
16 calendar year after 1991” and inserting “for cal-
17 endar years 1992 and 1993” and by striking the pe-
18 riod at the end and inserting “, and”, and

19 (3) by adding at the end the following new sub-
20 paragraph:

21 “(C) for any calendar year after 1993, an
22 amount without any limit.”.

23 (b) EFFECTIVE DATE.—The amendments made by
24 subsection (a) shall apply to calendar year 1994 and fol-
25 lowing calendar years.

1 **Subtitle B—Deductibility of**
2 **Certain Health Insurance Costs**

3 **SEC. 611. INDEFINITE EXTENSION OF DEDUCTION FOR**
4 **HEALTH INSURANCE COSTS OF SELF-EM-**
5 **PLOYED INDIVIDUALS.**

6 (a) IN GENERAL.—Subsection (l) of section 162 of
7 the Internal Revenue Code of 1986 (relating to special
8 rules for health insurance costs of self-employed individ-
9 uals) is amended by striking paragraph (6).

10 (b) EFFECTIVE DATE.—The amendment made by
11 subsection (a) shall apply to taxable years beginning after
12 December 31, 1993.

13 **SEC. 612. INCREASE IN AMOUNT OF DEDUCTION FOR SELF-**
14 **EMPLOYED INDIVIDUALS.**

15 (a) GENERAL RULE.—Paragraph (1) of section
16 162(l) of the Internal Revenue Code of 1986 is amended
17 by striking “25 percent of”.

18 (b) EFFECTIVE DATE.—

19 (1) IN GENERAL.—Except as otherwise pro-
20 vided in this subsection, the amendment made by
21 subsection (a) shall apply to taxable years beginning
22 after December 31, 1993.

23 (2) SPECIAL RULES FOR SELF-EMPLOYED INDIVIDUALS AND PERSONAL CORPORATIONS BEFORE
24 “PAY-OR-PLAY PROVISIONS” TAKE EFFECT.—
25

1 (A) IN GENERAL.—If the requirements of
2 subparagraph (B) are not met by any taxpayer
3 to whom this paragraph applies during any pe-
4 riod before the “pay-or-play” provisions take ef-
5 fect with respect to such taxpayer—

6 (i) in the case of a taxpayer described
7 in subparagraph (C)(i), the amount allow-
8 able as a deduction to such taxpayer under
9 section 162(l) of the Internal Revenue
10 Code of 1986 for amounts attributable to
11 such period shall be determined without re-
12 gard to the amendment made by sub-
13 section (a), and

14 (ii) in the case of a taxpayer described
15 in subparagraph (C)(ii), the amount allow-
16 able as a deduction under such Code for
17 amounts which are attributable to such pe-
18 riod and which are paid or incurred for
19 coverage provided to any employee-owner
20 under an accident or health plan of such
21 taxpayer shall be 25 percent of the amount
22 which but for this clause would have been
23 so allowable.

24 For purposes of clause (ii), the term “owner-
25 employee” has the meaning given such term by

1 section 269A(b)(2) of such Code with the modi-
2 fications provided in section 441(i)(2) of such
3 Code.

4 (B) REQUIREMENTS.—The requirements
5 of this subparagraph are met by any taxpayer
6 for any period if such taxpayer makes available
7 on the same terms and conditions health cov-
8 erage under a plan which would qualify as a
9 qualified employer health plan under title XXI
10 of the Social Security Act to all employees of
11 such taxpayer who normally work for 17½
12 hours or more per week.

13 (C) TAXPAYERS TO WHOM PARAGRAPH AP-
14 PLIES.—This paragraph shall apply to—

15 (i) any individual who is an employee
16 within the meaning of section 401(c)(1) of
17 such Code, and

18 (ii) any personal service corporation
19 (as defined in section 441(i)(2) of such
20 Code).

21 (D) WHEN “PAY-OR-PLAY” PROVISIONS
22 TAKE EFFECT.—For purposes of this para-
23 graph, the “pay-or-play” provisions take effect
24 on January 1, 1997, or, if earlier, the date on
25 which the requirements of part A of title XXI

1 of the Social Security Act apply with respect to
2 the taxpayer under section 2105(a) of such Act.

3 **SEC. 613. DEDUCTION FOR PREMIUMS PAID BY SMALL EM-**
4 **LOYERS FOR INSURANCE PROVIDING**
5 **QUALIFIED HEALTH COVERAGE.**

6 (a) IN GENERAL.—Part VI of subchapter B of chap-
7 ter 1 of the Internal Revenue Code of 1986 (relating to
8 itemized deductions for individuals and corporations) is
9 amended by adding at the end thereof the following new
10 section:

11 **“SEC. 197. PREMIUMS PAID BY SMALL EMPLOYERS FOR IN-**
12 **SURANCE PROVIDING QUALIFIED HEALTH**
13 **COVERAGE.**

14 “(a) IN GENERAL.—In the case of a small employer,
15 there shall be allowed as a deduction (in addition to any
16 amount otherwise allowable) an amount equal to 20 per-
17 cent of the premiums paid during the taxable year for in-
18 surance providing coverage under a qualified health plan
19 for employees of such employer.

20 “(b) SMALL EMPLOYER.—For purposes of this sec-
21 tion—

22 “(1) IN GENERAL.—The term ‘small employer’
23 means, with respect to the taxable year, an employer
24 that normally employs fewer than 100 employees on

1 a typical business day during the calendar year end-
2 ing with or within such taxable year.

3 “(2) CONTROLLED GROUPS.—All employers
4 treated as a single employer under subsection (a) or
5 (b) of section 52 shall be treated as a single em-
6 ployer.

7 “(c) QUALIFIED HEALTH PLAN.—For purposes of
8 this section, the term ‘qualified health plan’ means any
9 plan which meets the requirements of title XXI of the So-
10 cial Security Act and which provides only the minimum
11 benefits required under such title.”

12 (b) CLERICAL AMENDMENT.—The table of sections
13 for part IV of subchapter B of chapter 1 of such Code
14 is amended by adding at the end thereof the following new
15 item:

“Sec. 197. Premiums paid by small employers for insurance pro-
viding qualified health coverage.”

16 (c) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to premiums for coverage provided
18 after December 31, 1996.

19 **Subtitle C—State Maintenance of** 20 **Effort**

21 **SEC. 621. STATE MAINTENANCE OF EFFORT.**

22 (a) CONDITION OF COVERAGE.—Notwithstanding
23 any other provision of this title, no individual who is a
24 resident of a State is eligible for benefits under title XXII

1 for a month in a calendar year beginning with 1997, un-
2 less the State provides (in a manner and at a time speci-
3 fied by the Secretary) for payment to the Public Health
4 Trust Fund of $\frac{1}{12}$ of the amount specified in subsection
5 (b) for the year.

6 (b) MAINTENANCE OF EFFORT AMOUNT.—The
7 amount of payment specified in this subsection for a State
8 for a year is equal to the difference between—

9 (1) the amount of payment (net of Federal pay-
10 ments) that would have been made, for required
11 health benefits (as defined in section 2211(a)(2) of
12 the Social Security Act), under its State plan under
13 title XIX of such Act for the year if—

14 (A) title XXII of such Act were not in ef-
15 fect in the year, and

16 (B) the provisions of section 702(a) of this
17 Act (and section 1902(a)(13)(G) of the Social
18 Security Act, as added by section 702(b)) ap-
19 plied during the year as in 1996 (except that in
20 applying such provisions the references in sec-
21 tion 702(a)(1)(A)(iii) of this Act and section
22 1902(a)(13)(G)(ii)(III) of the Social Security
23 Act to “90 percent” are deemed references to
24 “100 percent”), and

1 (2) the amount of payment (net of Federal pay-
 2 ments) that is made, for required health benefits (as
 3 defined in section 2211(a)(2) of the Social Security
 4 Act), under its State plan under title XIX of the So-
 5 cial Security Act for the year.

6 (c) STATE DEFINED.—In this section, the term
 7 “State” means the 50 States and the District of Colum-
 8 bia.

9 **TITLE VII—MEDICAID** 10 **PROVISIONS**

11 **SEC. 701. COORDINATION WITH PUBLIC HEALTH PLAN.**

12 (a) IN GENERAL.—

13 (1) LIMITING FEDERAL FINANCIAL PARTICIPA-
 14 TION FOR SERVICES COVERED UNDER PUBLIC
 15 HEALTH PLAN.—Section 1903(i) of the Social Secu-
 16 rity Act (42 U.S.C. 1396b(i)) is amended—

17 (A) in the paragraph (10) inserted by sec-
 18 tion 4401(a)(1)(B) of Omnibus Budget Rec-
 19 onciliation Act of 1990, by striking all that fol-
 20 lows “1927(g)” and inserting a semicolon;

21 (B) by redesignating the paragraph (10)
 22 added by section 4701(b)(2) as paragraph (11),
 23 by transferring and inserting it after the para-
 24 graph (10) inserted by section 4401(a)(1)(B) of
 25 Omnibus Budget Reconciliation Act of 1990,

1 and by striking all that follows “with respect to
2 hospitals or facilities” and inserting a semi-
3 colon;

4 (C) by transferring and inserting the para-
5 graph (12) inserted by section 4752(a)(2) of
6 Omnibus Budget Reconciliation Act of 1990
7 after paragraph (11), as redesignated by sub-
8 paragraph (B), and by striking the period at
9 the end and inserting a semicolon;

10 (D) by redesignating the paragraph (14)
11 inserted by section 4752(e) of Omnibus Budget
12 Reconciliation Act of 1990 as paragraph (13),
13 by transferring and inserting it after paragraph
14 (12), and by striking the period at the end and
15 inserting a semicolon;

16 (E) by redesignating the paragraph (11)
17 inserted by section 4801(e)(16)(A) of Omnibus
18 Budget Reconciliation Act of 1990 as para-
19 graph (14), by transferring and inserting it
20 after paragraph (13), and by striking the period
21 at the end and inserting “; or”; and

22 (F) by inserting after paragraph (14), as
23 so redesignated, the following new paragraph:

24 “(15) with respect to items and services (in-
25 cluding medicare cost-sharing) for which payment is

(2) CLARIFICATION OF NONDUPLICATION OF MEDICAL ASSISTANCE WITH BENEFITS UNDER PUBLIC HEALTH PLAN.—Title XIX of such Act is amended by adding at the end the following new section:

8 “NONDUPLICATION OF BENEFITS WITH PUBLIC HEALTH
9 PLAN

10 “SEC. 1931. Notwithstanding any other provision of
11 this title, a State is not required under its plan under sec-
12 tion 1901(a) to provide medical assistance for items and
13 services (including medicare cost-sharing) for which pay-
14 ment is made under the public health plan under title
15 XXII.”.

(3) CLARIFICATION OF APPLICATION OF THIRD-PARTY PAYOR RULES TO QUALIFIED HEALTH PLANS.—Section 1902(a)(25)(A) of such Act (42 U.S.C. 1396a(a)(25)(A)) is amended by inserting “and qualified health plans certified under part F of title XXII” after “health insurers”.

(b) CONTINUATION OF MEDICAID BENEFITS NOT COVERED UNDER PUBLIC HEALTH PLAN.—Nothing in this Act shall be construed as—

1 (1) changing the eligibility of individuals for
2 medical assistance under title XIX of the Social Se-
3 curity Act, or

4 (2) subject to the amendments made by sub-
5 section (a), changing the amount, duration, or scope
6 of medical assistance required (or permitted) to be
7 provided under such title.

○

HR 1398 IH——2

HR 1398 IH——3

HR 1398 IH——4

HR 1398 IH——5

HR 1398 IH——6

HR 1398 IH——7

HR 1398 IH——8

HR 1398 IH——9

HR 1398 IH——10

HR 1398 IH——11

HR 1398 IH——12

HR 1398 IH——13

HR 1398 IH——14